UBO

"MTF Revenue Cycle Management"

Strengthening The Back End Processes

Cost Recovery Program
Manager's Training

Metrics and You

Lt Col Yoder
jeanne.yoder@tma.osd.mil

Overview

- Third Party Collection (TPC) Metrics sent "forward"
- TPC Metrics YOU should also review
- Medical Service Accounts (MSA) Metrics
- Medical Affirmative Claims (MAC) Metrics
- Remember:
  - Third Party Inpatient=MSA CHCS
  - Third Party Outpatient=TPOCS

Questions Managers Need to Ask

- What are bottlenecks/problem areas?
- What monies are owed?
- Are there specific payors?
- Does everyone in the MHS have these same problem payors?
- How have other MTFs resolved these problems?
- What is the best allocation of my resources?
- What do my people need? Training? Software?

1. TPC Metrics sent "forward"

- Number and Dollar amount of Outpatient Claims – Quarterly
  - (TPOCS Reports->Tracking->Number of Claims Processed)
- Those bills actually out the door, not just generated by TPOCS
  - # in TPOCS not sent because they require work (on 1st of each month by clerk. These can be found in the bill queue and will be beyond the suspense hold date (manual process))
  - How does this compare to last quarter? to this quarter last year?
  - How does it compare to MTFs similar to yours? (a metric tool will be on the web in 05)
  - Will you meet your MTF's goal if you continue at this rate?

2. TPC Metrics sent "forward"

- Number of Inpatient Claims – Quarterly
  - Report in MSA CHCS: DD Form 2570 (MSA-IFM-QRP-PRR; Block 3)
- These are the institutional claims generated by taking the DRG and adding the professional percentage
- This should NOT include inpatient rounds as those should all be in the A-MEPRS and should not feed over. DO NOT bill inpatient rounds at this time
- What percentage of total discharges is this? What was the number in relation to last quarter? to this quarter last year?
  - Report in MSA CHCS: DD Form 2570 (MSA-IFM-QRP-PRR; Block 5)
- How does this compare to other facilities similar to yours?
  - Table on the web…. FY 05

3. TPC Metrics sent "forward"

- Collected to Billed Outpatient Ratio – Quarterly
  - Manual process for outpatient
  - #'s needed are on the DD Form 2570
- Use claims per visit
- CFY and PFY
- Look at this compared to the amount billed last quarter – you should be getting paid in approximately 45 days

4. TPC Metrics sent "forward"

- Collected to Billed Inpatient Ratio – Quarterly
  - DD Form 2570 (MSA-IFM-QRP-PRR; manually calculate)
- Use claims per visit
- CFY and PFY
- Look at this compared to the amount billed last quarter – you should be getting paid in approximately 45 days

5. TPC Metrics sent "forward"

- Claims per Visit, Outpatient, Quarterly
  - Manual Process
- % of non-Active Duty visits with claim(s) – Quarterly
- APV, Clinic, Pharmacy

5. TPC Metrics sent "forward"

- What percentage of total discharges is this? What was the number in relation to last quarter? to this quarter last year?
  - MSA CHCS: DD Form 2570 (MSA-IFM-QRP-PRR; Block 5)
  - TPOCS is reported manually
- CFY, PFY

6. TPC Metrics sent "forward"

- Claims per Disposition Inpatient, Quarterly
  - Report in MSA CHCS DD Form 2570 (MSA-IFM-QRP-PRR, Block 5)
- CFY, PFY

7. TPC Metrics sent "forward"

- Collection Goals Inpatient and Outpatient – Annually – and updated quarterly (Not: Goals come from Service Managers, Comparison reports from you)
  - DD Form 2570 (MSA-IFM-QRP-PRR, Manual Calculation)
  - DD Form 2570 (Reports – DoD Reports)
- Initial, collections, percent

8. TPC Metrics sent "forward"

- Other Health Insurance Compliance; medical record and CHCS – both must be current and the same
  - DQMC http://www.tricare.osd.mil/ebc/files/fa/TMA-Summary-Jul-04.xls
- DD Form 2569 in the non-active patient record within the past 12 months and current in CHCS

9. TPC Metrics sent "forward"

- Billing (Manual and Electronic)
  - TPOCS Tracking Report (Manual Preparation: Subtract Electronic Billing Report from the Tracking Report)
- Number of Claims in Accounts Receivable
  - 0-90
  - 91-180
  - 181-270
  - 271+
  - From date of service/discharge

  (AR Reports)

10. TPC Metrics sent "forward"

- Number of Claims Processed to Date for Current FY
  - TPOCS Tracking Report (Manual Preparation: Subtract Electronic Billing Report from the Tracking Report)
- Sum of all claims processed electronically and manually
  - 0-90
  - 91-180
  - 181-270
  - 271+
  - From date of service/discharge

  (AR Reports)

1. TPC Metrics you should also review

- Number and Dollar amount of Outpatient Claims – Quarterly
  - Those actually out the door, not just generated by TPOCS
- Split out by APV surgeon/institutional, APV anesthesia, Clinic, Pharmacy (in house and from down town), Ancillaries, Other

2. Metrics for You to Review

- Precertification – obtaining insurer authorization for elective surgeries/procedures or elective admissions prior to surgery or admission
  - 95% for Elective Surgeries/Procedures
  - 95% for Elective Admissions
- After-the-fact Certifications for Emergency Surgeries/Procedures/Admissions
  - 95% within 8 duty hours of the emergency service
  - Report – Manually Tracked

3. Metrics for You to Review

- Billing turnaround (5 days from date of service in civilian sector) – 2 days from generation of bill
- Report
- % clean claims submission – 97%
- Report
- Payor turnaround (average time to pay clean claim
  - Electronic – 10 days
  - Paper – 45 days

Manually Track or request Ad Hoc Report

4. Metrics for You to Review

- Claim rejection turnaround – 15 days
- Manual Process
- High-dollar unpaid accounts worked – less than 5% over 60 days
- Manual Process
- Low-dollar unpaid accounts worked – less than 10% over 60 days
- Manual Process

5. Metrics for You to Review

- Gross days receivable outstanding
  - TPOCS and CHCS, AR Ad Hoc
  - Fewer than 50 days outstanding
- Net days receivable outstanding
  - TPOCS and CHCS, AR Ad Hoc
  - Fewer than 50 days outstanding

6. Metrics for You to Review

- % Accounts Receivable greater than 90 days – less than 20 %
- % Accounts Receivable greater than 120 days – less than 10 %
- % Accounts Receivable greater than one year – less than 2%
- Credit Balance on Accounts Receivable – fewer than 2 days

7. Metrics for You to Review

- By payor:
  - TPOCS – TPC Summary by Insurer
  - CHCS – Manual Process (Ad Hoc)
  - % paid on average
    - e.g., Total paid in last year/total billed in last year
  - % of claims greater than $10K/$5K that "vanish" or "were never received"
  - % of inpatient claims that were more than 10% denied (e.g., claim for $4,500, partial denial of more than $450)

8. Metrics for You to Review

- Look over all your reasons for denials
  - Request additional information (what info, e.g., operative report, advance notification)
  - Timeframe for Submission Expired
  - Timeframe for Appeals Expired
  - Wrong Appeals Address
  - Member not found
  - Member not eligible
  - Wrong Payor Address
  - Not PPO network

Comparisons in MHS

3rd Qty 2003		Army	Navy	Air Force	All Svc
Inpatient	**Adjust to U&C**	17.09%	9.85%	4.55%	**10.57%**
	Not Covered	6.54%	14.71%	14.49%	**11.66%**
	Med Supp Inc	0.21%	0.71%	5.04%	**2.08%**
	Medicare	36.89%	38.60%	64.73%	**47.37%**
	HMO	2.69%	3.97%	1.85%	**2.74%**
	MTF Compliance	0.00%	0.13%	0.42%	**0.19%**
	Refunds	0.11%	0.00%	0.00%	**0.04%**
	Copay/Deductible	15.20%	4.69%	7.35%	**9.46%**
	Other	21.27%	27.34%	1.56%	**15.87%**
	Other2	0.00%	0.00%	0.01%	**0.00%**

Comparisons in MHS

3rd Qty 2003		Army	Navy	Air Force	All Svc
Outpatient	Adjust to U&C	9.90%	12.98%	5.13%	**7.98%**
	Not Covered	21.93%	13.27%	23.18%	**20.96%**
	Med Supp Inc	0.02%	0.11%	0.40%	**0.23%**
	Medicare	3.18%	4.53%	8.31%	**6.12%**
	HMO	0.25%	1.48%	0.96%	**0.85%**
	MTF Compliance	0.48%	0.10%	0.12%	**0.22%**
	Refunds	0.05%	0.00%	4.08%	**2.15%**
	Copay/Deductible	48.14%	53.12%	46.36%	**48.14%**
	Ccother	12.82%	5.14%	6.24%	**7.94%**
	Other2	3.24%	10.48%	6.93%	**6.53%**

9. Metrics for You to Review

- Clerk Productivity
  - % denied allowed (and what types of denials)
  - # of bills out by type (e.g., inpt, UB92, CMS 1500, UCF)
  - $ of bills out by type
  - % ($ and # AR) over 60 days, greater than $5K not worked
  - % ($ and # AR) over 90 days, less than $5K not worked
  - % ($ and # AR) over 120 days !!!

MSA Metrics

- Non-eligible/Civilian Emergencies
  - # and $ submitted (by category, e.g., inpt, UB92, CMS 1500, UCF) by quarter
  - AR greater than 60 days
  - AR greater than 90 days
  - AR greater than 120 days
- Interservice billing/Foreign National
  - Compare to previous quarters, notice large variations

MAC Metrics

- Injury Logs from ER/FP every day, forwarded to JAG
- Log responses from JAG
- # open claims,
  - Total number
  - # open claims over 365 days
  - # open claims over 2 years
- # claims closed in month
- # claims w/o visits for more than 90 days

Review

- Metrics sent to HQ/TMA/Congress
- Metrics YOU want to see (and understand)
- MSA
- MAC

Questions?

Seven Points of Opportunity

Dawn Canales

Overview

- Requirement to Collect Insurance and Injury Information
- Seven Entry Points
- Affects of Not Collecting
- Tactics for Gaining Staff Support
- Effective Staff Training
- Measuring Results and Providing Feedback

Requirement to Collect Insurance and Injury Information

- Authority
  - Title 10, USC Section 1095
  - 32 CFR, Part 220
- Requirements - DoD 6010.15
  - Chapter 3 - MSA
  - Chapter 4 - TPC
  - Chapter 5 - MAC

Seven Entry Points

1. Clinics
2. Emergency Room
3. Pharmacy
4. Laboratory
5. Radiology
6. Admissions
7. TRICARE Customer Support

Seven Entry Points

- DEERS will be central repository for OHI
- Several ways to query/update OHI
- System defaults
  - "Do you want to Add/Edit the Patient's OHI Data Now?" [Yes]

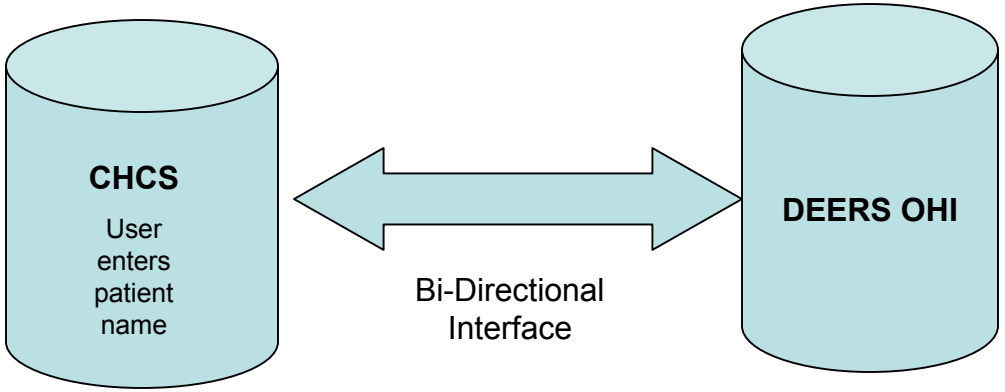
OHI Inquiry to DEERS

CHCS Menu Path #1: Patient Insurance Information (PII)

CA→PAD→ROM→PII→ enter Patient Name

Front desk staff

Appt Clerks

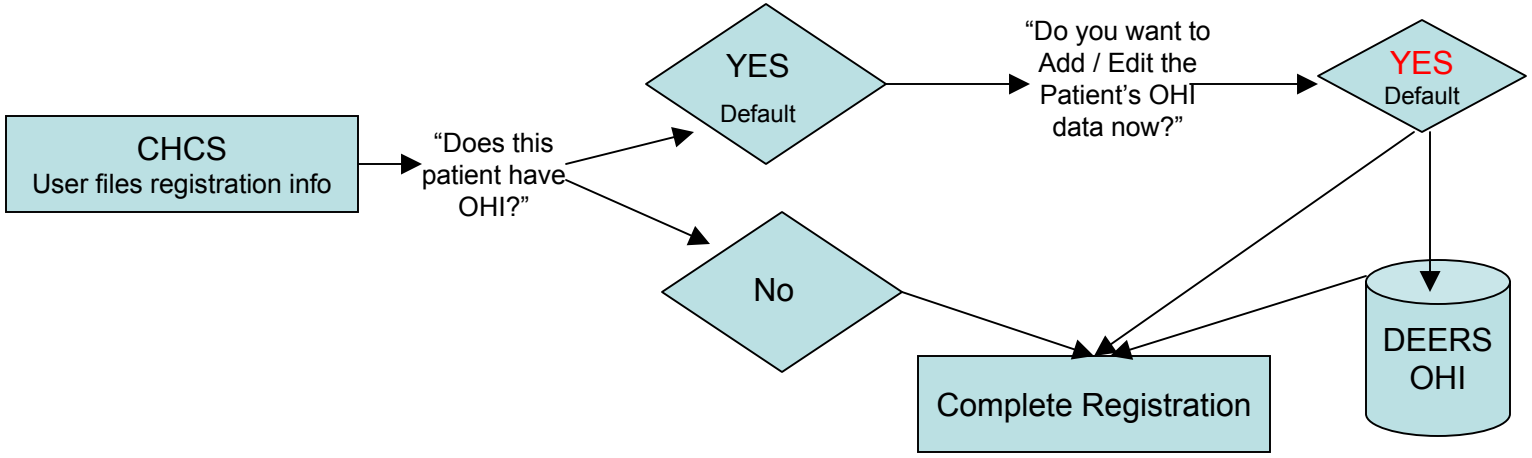


- User enters a patient name
- CHCS will query DEERS for existing OHI Information associated with the selected patient.
- The data returned from DEERS will display on the OHI screen..

OHI Inquiry to DEERS

CHCS Menu Path #2: Mini/Full Registration

CA→**PAD**→**ROM**→**FRG** or **MRG**→ **Patient Name** →enter/edit registration information



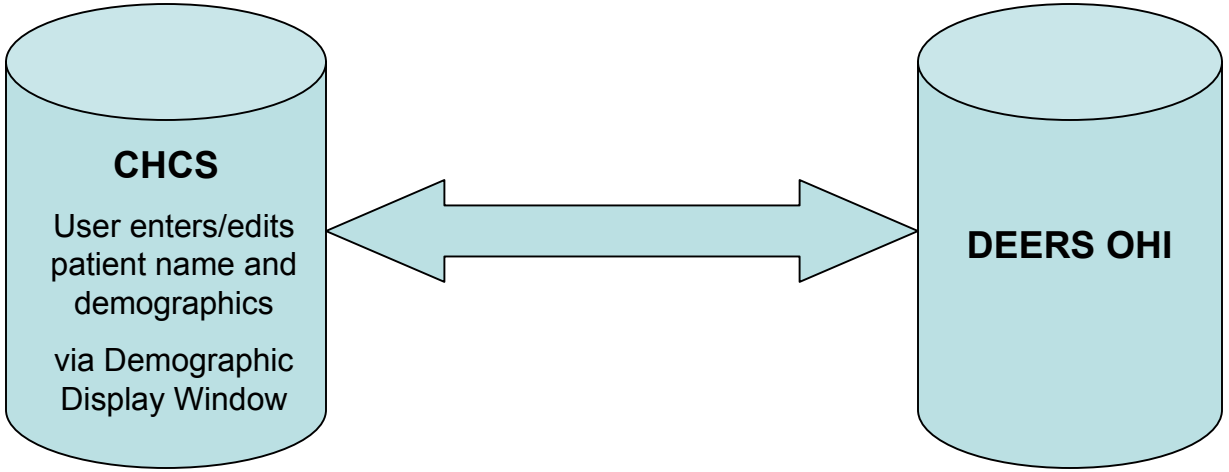
CHCS queries DEERS for existing OHI. The data returned from DEERS displays on the OHI screen.

When a user accesses full registration or mini-registration, the user is presented with the opportunity to enter/edit OHI information for TPC eligible beneficiaries.

OHI Inquiry to DEERS

CHCS Menu Path #3: Demographics Display Window

CA→PAS→MCP→ Health Care Finder or **Front Desk** option
→ enter Patient name→(**D**)emographics→(**O**)HI→ DEERS OHI query

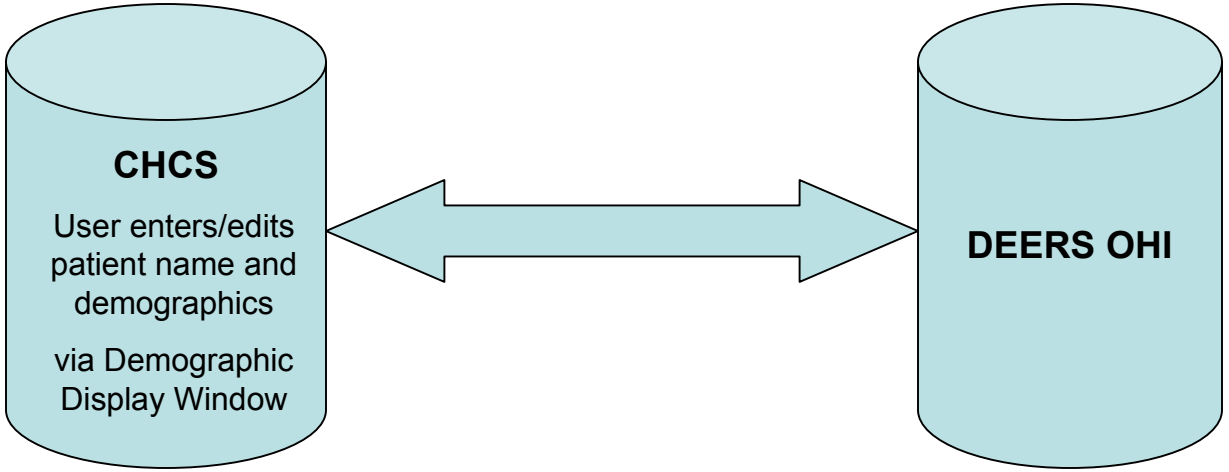


The OHI enter/edit capability is accessible via the Demographic Display window in any Managed Care Program option where patient demographics are entered or edited for a TPC eligible beneficiary.

OHI Inquiry to DEERS

CHCS Menu Path #4: Emergency Room

CA→PAS→ Emergency Room Menu →NER, WER, or **RER**
→enter Patient Name→(**D**)emographics→(**O**)HI→DEERS OHI query

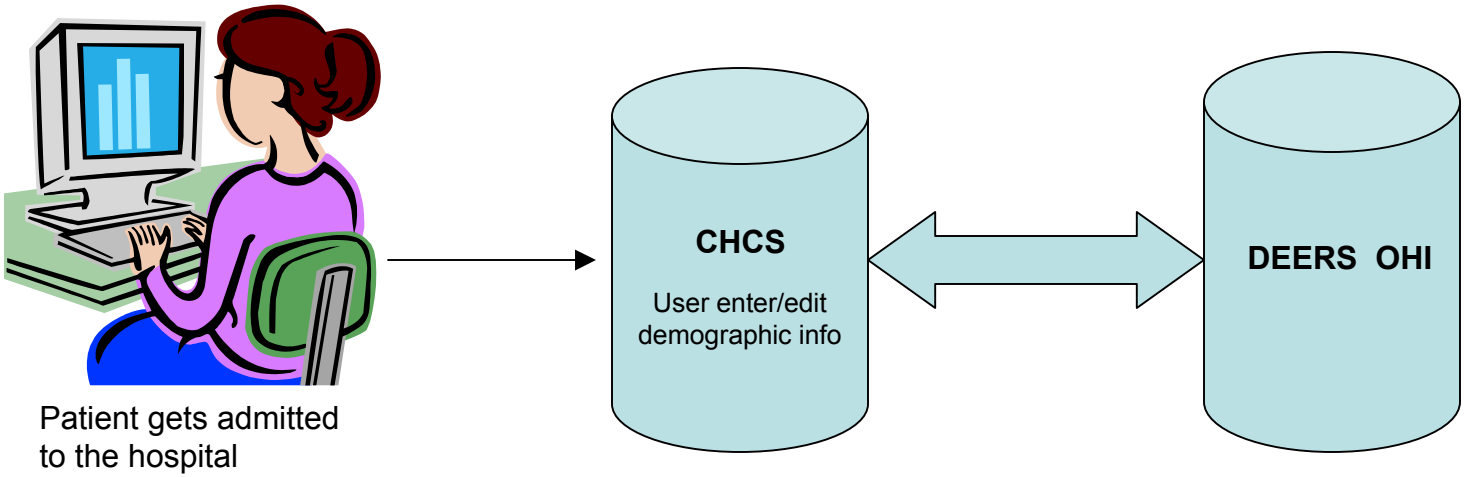


The OHI enter/edit capability is accessible via the Demographic Display window in any Emergency Room option where patient demographics are entered or edited for a TPC eligible beneficiary.

OHI Inquiry to DEERS

CHCS Menu Path #5: Admission Inpatient

CA→**PAD**→**ADT**→**ADM**→Enter Patient Name→enter/edit demographics→DEERS OHI query

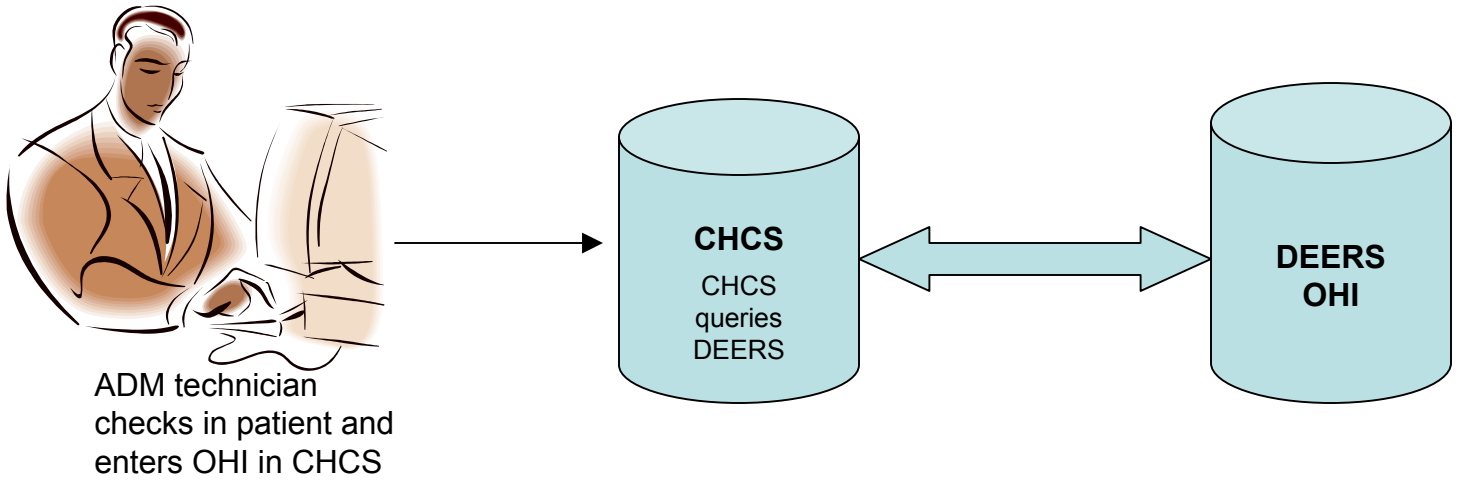


When patients are admitted to the hospital as inpatients, immediately following the enter/edit of demographics, the system sends a query to the DEERS OHI database

OHI Inquiry to DEERS

CHCS Menu Path #6: Ambulatory Data Module (ADM)

ADS (secondary menu option) →1 **ADM Data Entry Menu** →3 **Clerk Check-in Processing** →**select location**→ **Select Provider** → **select appointment data range** → **select Patient** → complete encounter data entry → Ohi & Demog→(**O**)hi→DEERS OHI query

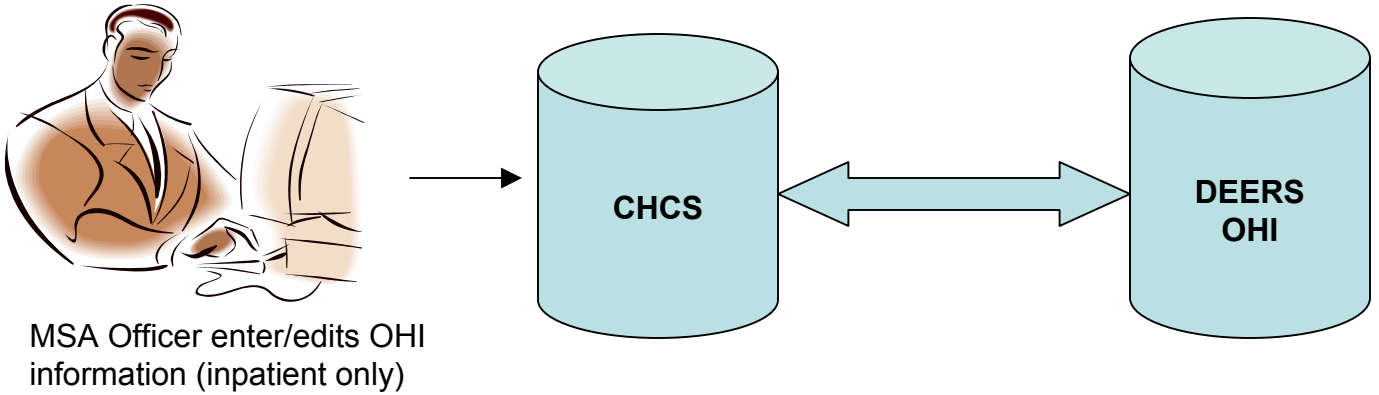


When the Ambulatory Data Module (ADM) clerk checks in a patient during Encounter processing, the clerk is prompted to enter OHI for the selected patient.

OHI Inquiry to DEERS

CHCS Menu Path #7: Medical Services Account (MSA)

CA→MSA→IFM→IAP→ select Patient or Account→5 or 8



MSA Officer enter/edits OHI information (inpatient only)

When the MSA user is processing an account, the user is provided an opportunity to enter/edit OHI information (inpatient episodes only).

Negative Affects of Not Collecting

- "Unclean" Claims
- Rework
- More work on the back end

Tactics for Gaining Staff Support

- Maintain Visibility
- Solicit performance improvement ideas rather than recommend
- Case Study

Providing Effective Staff Training

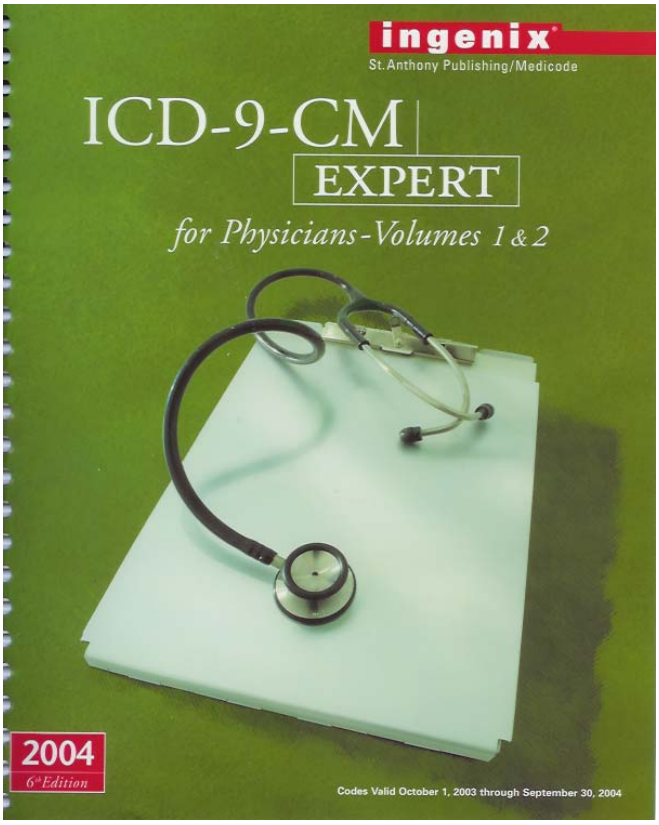
- Just-in-time
- One-on-one is best
- Self paced for refresher
- Interview techniques

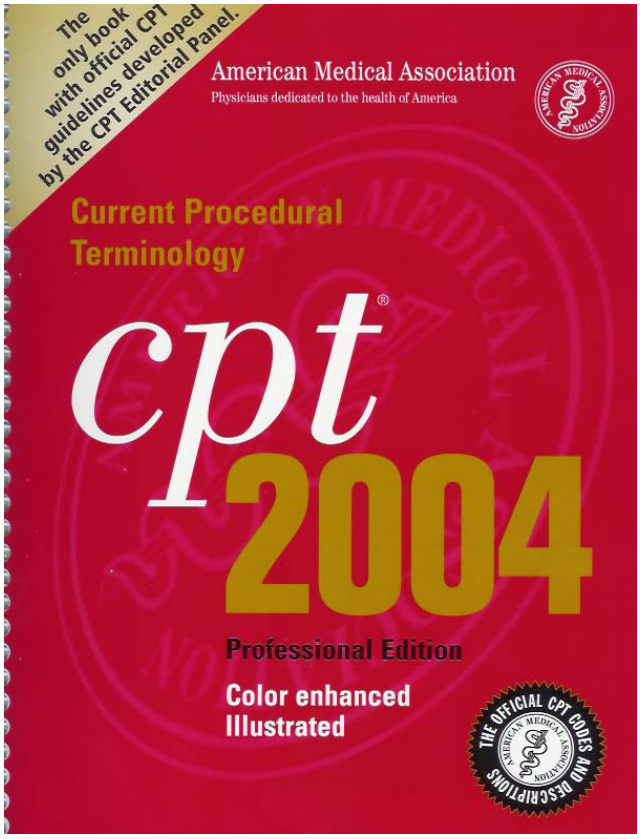
Measuring Results and Providing Feedback

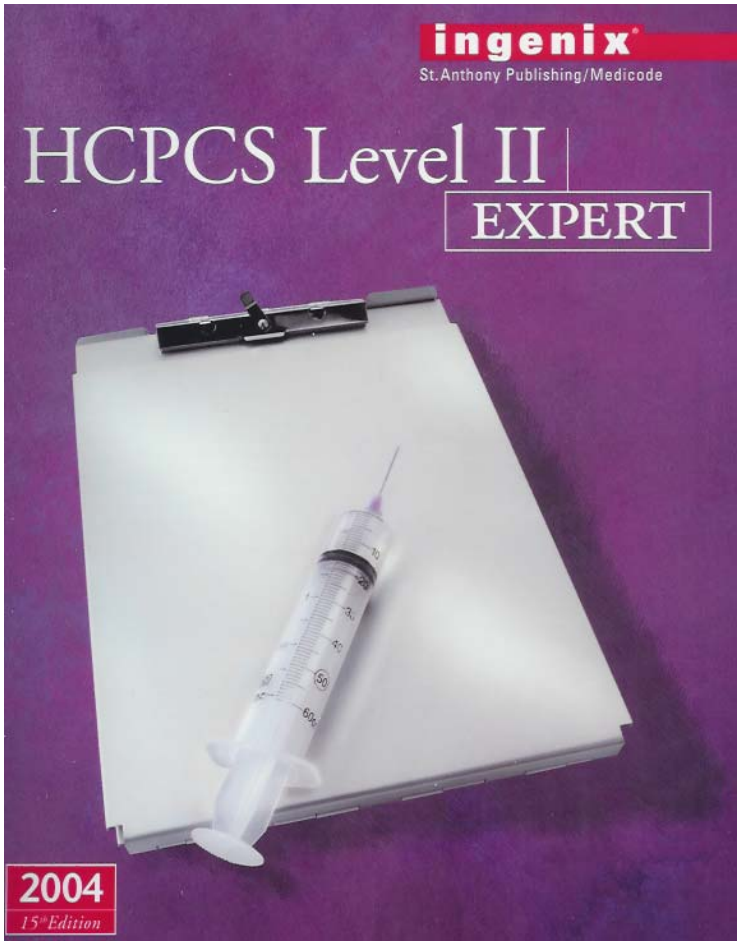
- Complete audits
- Compile statistics to determine compliance rate
- Present to key executive staff

Questions?

The Books


ingenix
St. Anthony Publishing/Medicode
ICD-9-CM
EXPERT
for Physicians - Volumes 1 & 2
2004
6th Edition
Codes Valid October 1, 2003 through September 30, 2004


The only book with official CPT guidelines developed by the CPT Editorial Panel.
American Medical Association
Physicians dedicated to the health of America
Current Procedural Terminology
cpt®
2004
Professional Edition
Color enhanced
Illustrated
THE OFFICIAL CPT CODES AND DESCRIPTIONS


ingenix
St. Anthony Publishing/Medicode
HCPCS Level II
EXPERT
2004
15th Edition

ICD-9-CM

- 3 Volumes
  - 1 and 2 – Diagnoses
  - 3 – Inpatient Procedures

- Shows medical necessity for outpatient
  - CMS1500
- Diagnosis and procedure = Diagnosis Related Group (DRG)
  - UB92

ICD-9-CM

- Alphabetic
- Tabular
- 3 digits:decimal point:1 or 2 more digits
- V:2 digits:1 or 2 more digits
- E:3 digits:1 more digit

CPT

- Professional Services
- Written by AMA to get money back from insurance companies
- Will you find uniquely cosmetic procedures?
- Will you find “institutional” codes?
- Will you find “Dental” codes?

CPT

- In general, have relative value units
- 5 digits
- 4 digits:F
- 4 digits:T
- May have 2 digit modifiers
  - Up to 3 of them
  - -25, -26, -50, -51, -57, -AA, -RT, -LT, - F1

Example

- Diagnosis: Sinusitis
- Lab: Hem A1C

- Mod to change from 1st dx
- But if Diabetes is not listed, need to speak with coder to teach physician

HCPCS

- Other than professional services
  - Ambulance
  - Dental
  - Supplies
  - Nurse/tech stuff
  - Education

HCPCS

- Letter:4 digits
- May have 2 digit modifier

Rates

- Pharmacy
- Outpatient
- Inpatient
- Ambulance
- Anesthesia
- Cosmetic
- Institutional outpatient

Data Quality Management Control Program (DQMC) Update

Purpose

- To provide an update on the status of the Data Quality Management Control (DQMC) Program in the MHS for FY04 as it impacts Revenue Cycle Management
- And pertinent current month's (July Reporting Period/May Data Month) Data Quality Commander's Statements submitted by the Services

Implementation 1 Dec 00 (FY01)

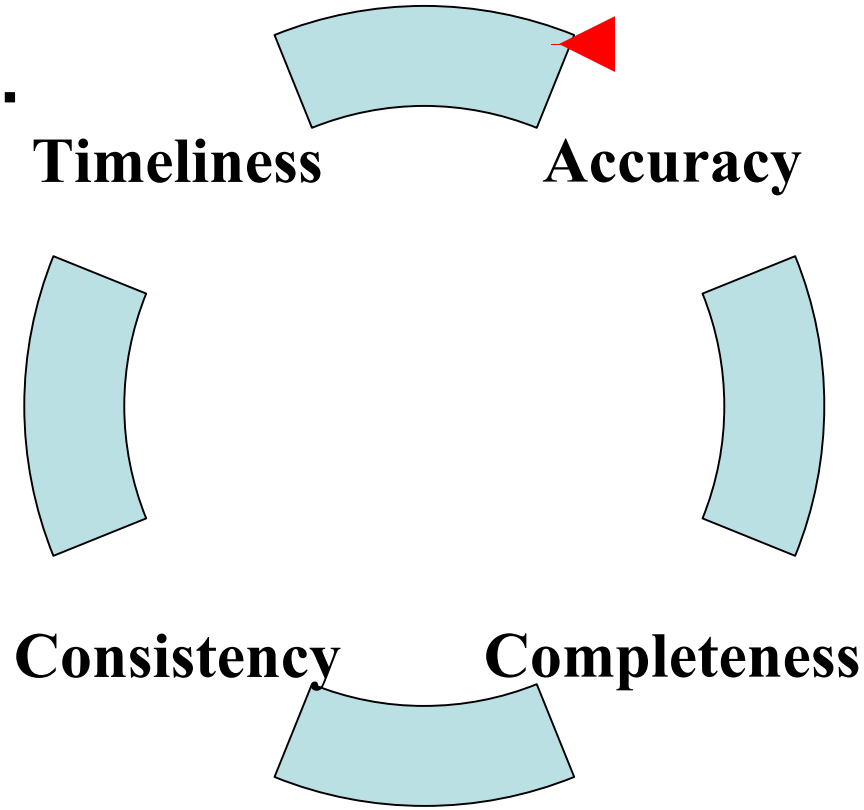
2004 UBO Pilot Training

"Strengthening the Back End Processes"

Provisions in the new Medicare law signed by President Bush this week provide financial incentives to physicians and hospitals that participate in the monitoring and improvement of health care protocols, the Associated Press reports. According to the National Committee for Quality Assurance, "too few" health care organizations currently allow themselves to be monitored, and many potentially jeopardize patient safety by not following best practices. To promote quality reporting, the new Medicare law requires the Institute of Medicine to create uniform quality standards for health care providers as well as an incentive plan that will give physicians higher Medicare payments if they meet or exceed certain performance standards.

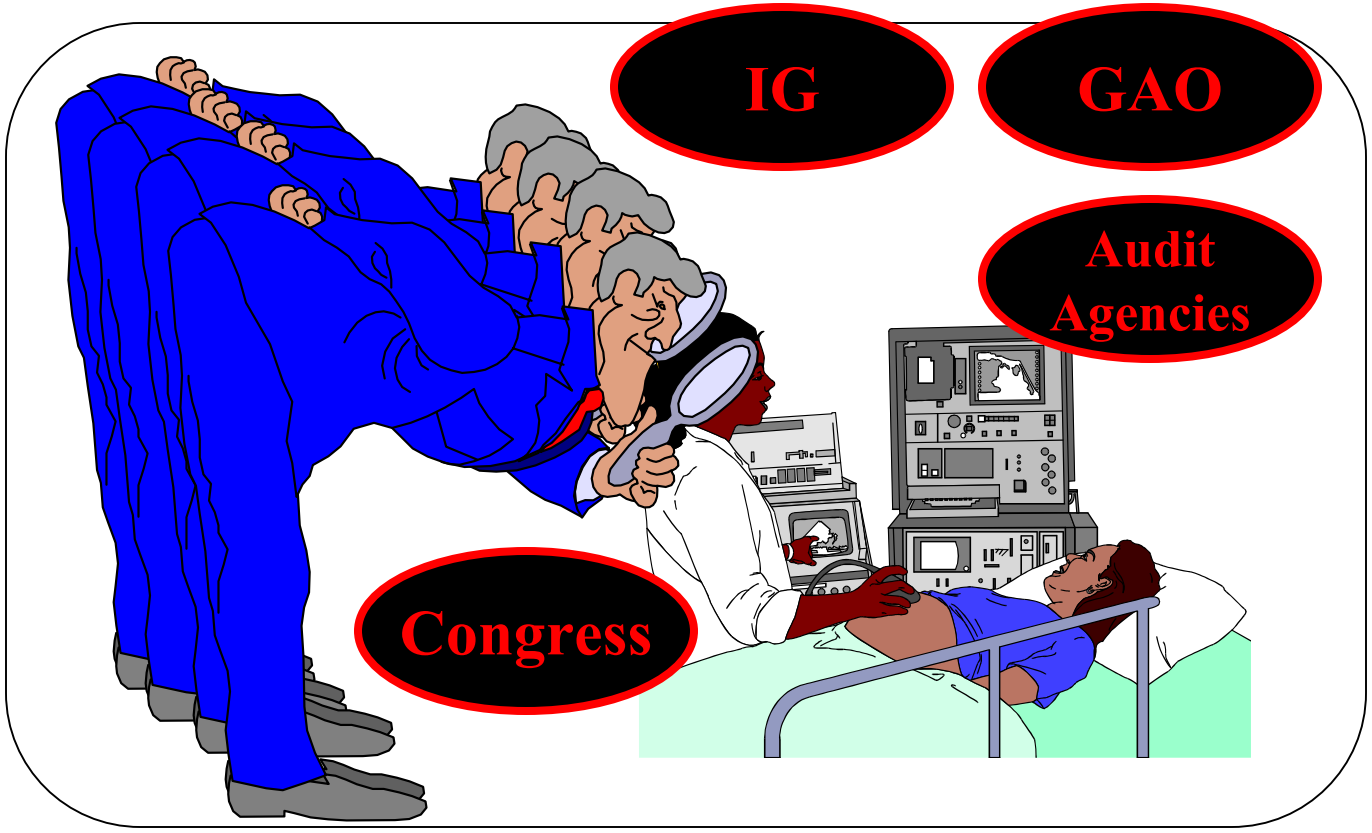
The new law also grants a 0.4% increase in Medicare reimbursements to hospitals that submit quality data to CMS. In addition, the law requires that the Medicare regional PPO—which will become effective in 2006—report data in order to continue participating in Medicare. According to one NCQA official, the law's quality reporting provisions will allow people to be better informed when selecting medical coverage, and it will allow government officials to better assess the quality of care that Medicare provides. Officials from the Leapfrog Group say they hope the new quality reporting requirements will pave the way for providers in the private sector to expand their quality reporting efforts (AP/New York Times, 12/11).

- **Attributes…**



Why Worry about Data Quality?

One reason is external scrutiny...



Why Worry about Data Quality?

More importantly, poor data quality hurts our own efforts to improve...

Problems with Information Technology

- Typically, Data Quality is formulated as an IT problem..
  - Some of our problems with data quality can be attributed to problems with Information Technology (IT).
  - Examples:
    - Errors in transmission of data.
    - Errors in processing data.
    - Unsynchronized databases.
- But…
  - The most difficult problems we face with data quality are not directly attributable to IT, nor readily fixed by IT solutions.

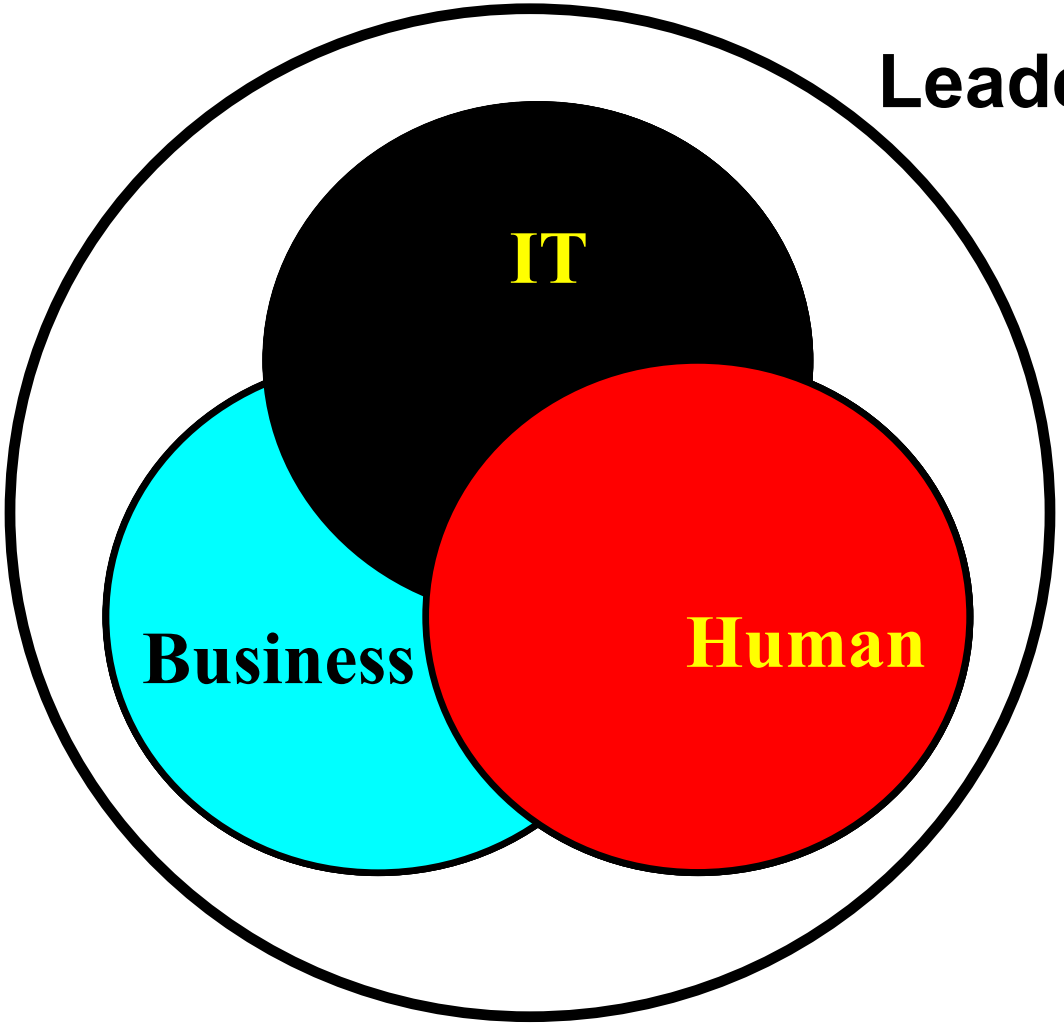
Non-Technological Problems

- **Just a few examples of non-IT problems causing problems with data quality...**
  - **Lack of standardized business rules and policies.**
  - **Inconsistent choices of codes, weights, and algorithms.**
  - **Lack of adequate training and education.**
  - **Lack of adequate local data quality assurance.**
  - **Failure to set and enforce tough performance expectations about data quality.**

Why is this Important?

- **Consequences of an incorrect diagnosis or an overly simplistic formulation of the problem…**
  - **Treat only part of the problem.**
  - **Don't treat serious problems that need fixing.**
  - **Responsibility, accountability, resources in the wrong places.**

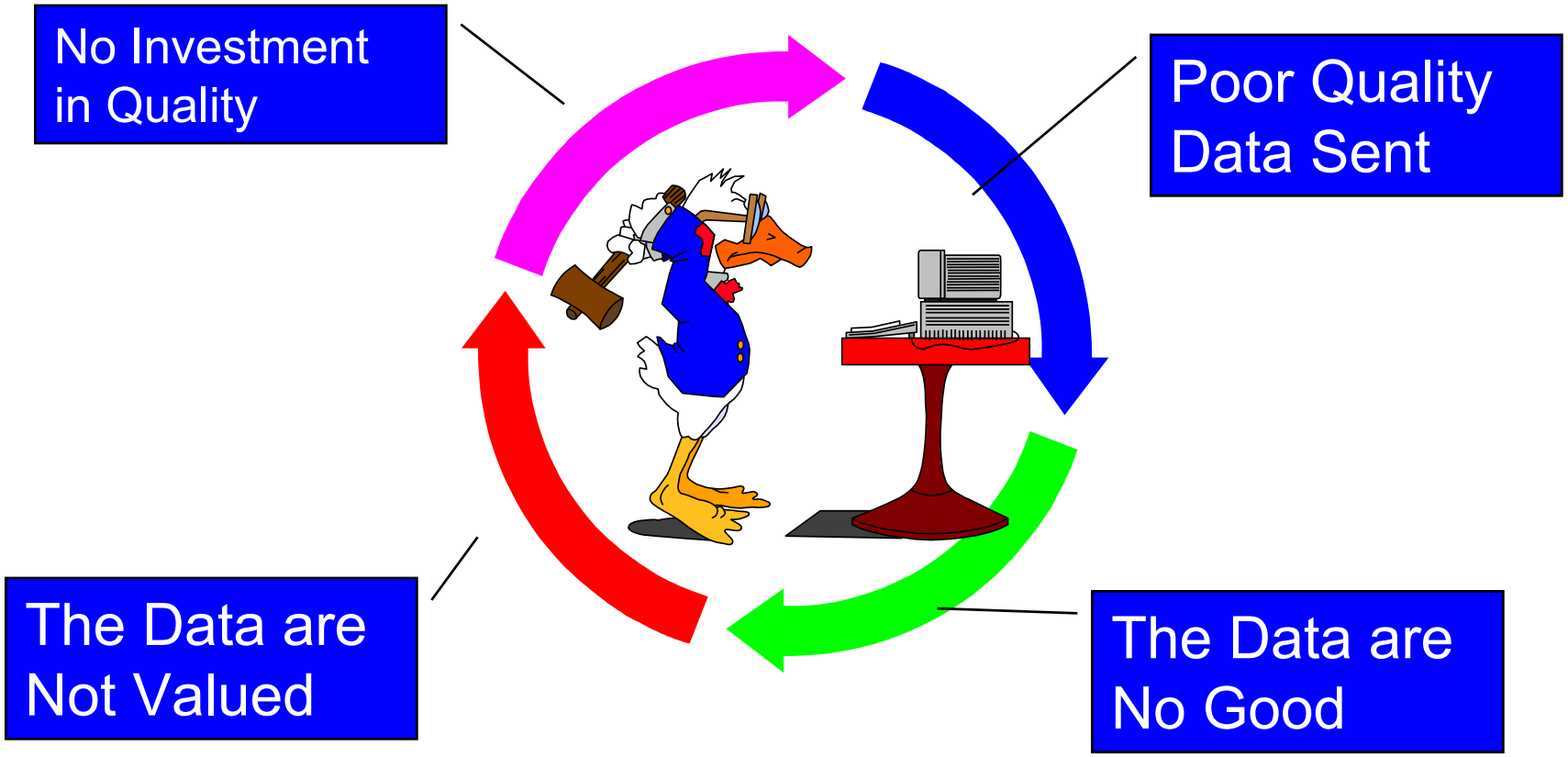
Complex Paradigm for a Complex Problem



So, What Can We Do About Data Quality?

- Emphasize Senior Level Leadership.
- Solve the business problems.
- Coordinate IT solutions that follow the business.
- Training and Education.
  - MHS employees must understand the business.
  - Employees using automation, must understand their responsibilities.
- Provide Timely Feedback.
- Provide Support.
- Internal and External Management Control.
- Fix IT Problems.

Locked in a Vicious Circle



Training and Education

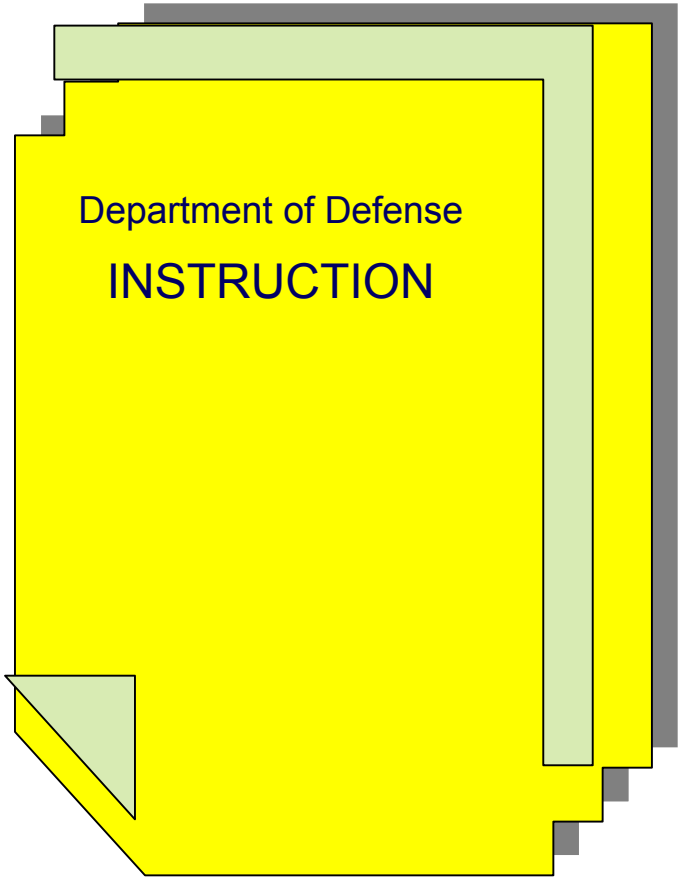
- Our people have to understand both the business and the technology…
  - Data Quality Training Course.
    - Aimed at data quality managers and others.
  - Education: Quality data requires more than training data-entry personnel
    - TRICARE Financial Management Education Program (TFMEP)
    - Working Information Systems to Determine Optimal Management Course.
    - MEPRS Application and Data Improvement Course.

Information Technology

- Complete redesign of Corporate Information Systems.
  - Synchronization of databases.
  - Consistent engineering of data paths from source to central repository.
  - Quality control built into data feeds.
- Redesign of user interfaces.
- Elimination of Human Interfaces between Systems.

Regulatory Guidance

DODI 6040.40
Military Health System
Data Quality
Management Control
Procedures



MHS DQ Management Control Program

Background

- DoD-IG identified material management control weakness for MHS - Directed development of data quality assurance and management control program.
- DoD Inspector General report concerning the FY98 retirement liability estimate.
- GAO Medicare subvention demonstration report.
- ASD(HA) concurred with DoDIG material management control weakness findings.
- ASD(HA) designated TMA Resource Management Steering Committee to oversee the development of an MHS DQ Management Control Program.

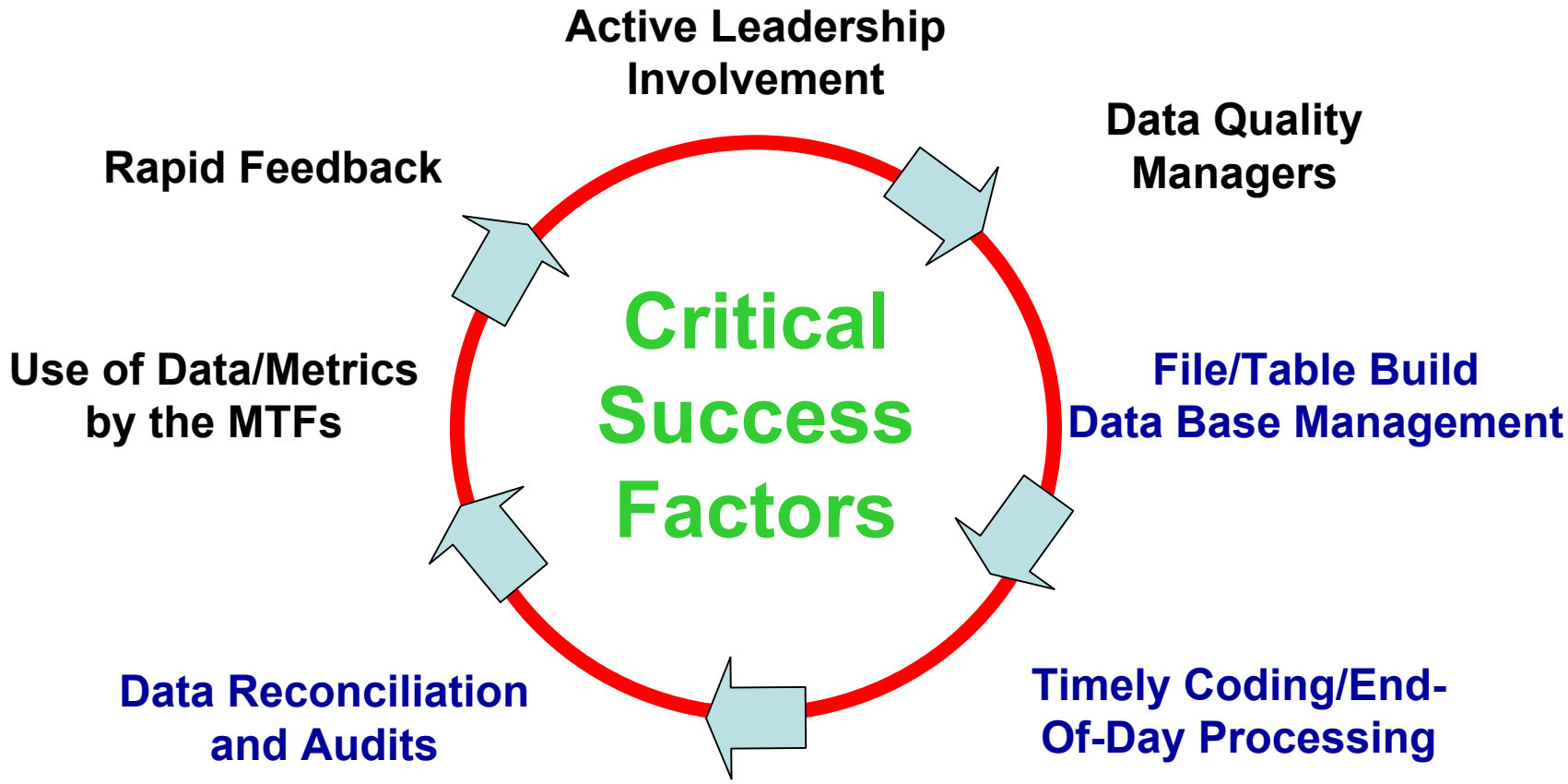
MHS DQ Management Control Program

Components of Program

- **Data Quality Manager** and **Data Quality Assurance Team**
- **DQMC Review List** - Internal tool to assists MTFs monthly in identifying and correcting financial and clinical workload data problems. This list is prepared by the Data Quality Manager and Data Quality AssuranceTeam.
- **Commander's Monthly Data Quality Statement** – Specific information from the DQMC Review List that the commander approves for forwarding to Service DQ managers and the TMA Management Control Program Manager.

MHS DQ Management Control Program

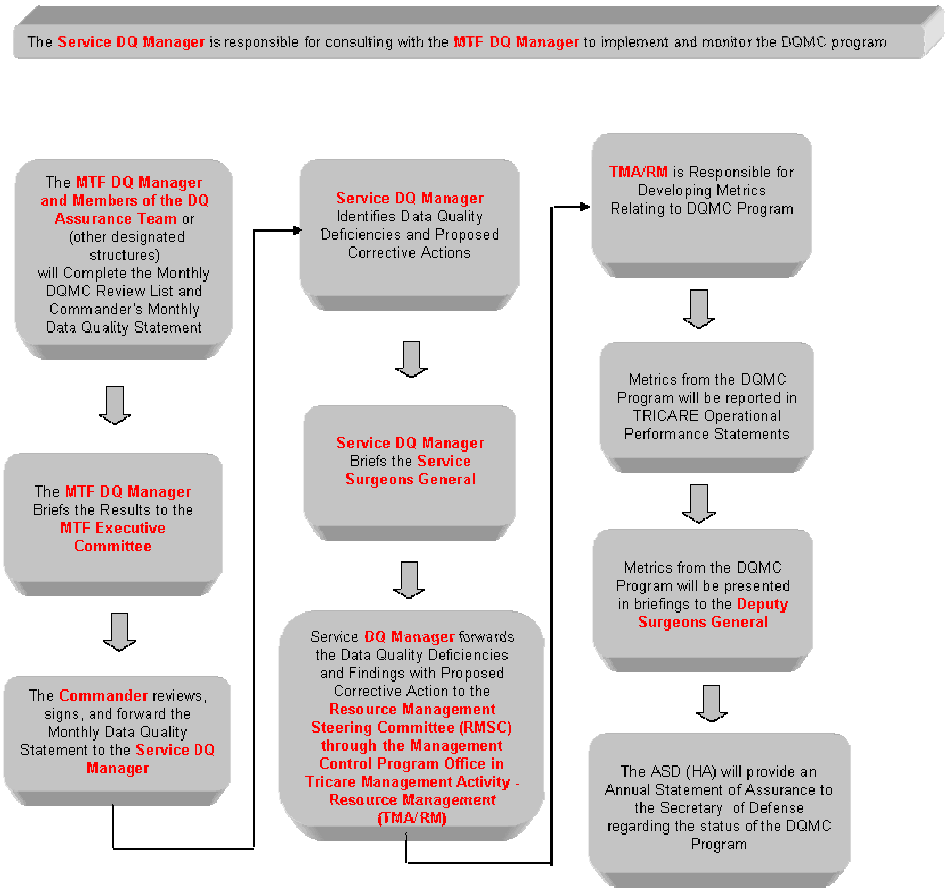
Components of Program



MHS DQ Management Control Program

What Does TMA Do?

- **Commander's Statements** are received from Services on the 10th of the month for the preceding month.
- A summary **"Barber Pole"** along with supporting charts are constructed for briefs to both the Resource Management Steering Committee on a monthly basis and TMA Senior Leadership and Service DSGs Quarterly
- These charts along with an updated **"Hard Spots List"** are distributed to the Service DQMC POCs for their monthly meeting at TMA-RM.
- **Service and TMA-Wide** issues are discussed and documented at these meetings.
- **Mr. David Fisher, Director of Management Controls & Financial Studies, Office of the CFO, TMA POC.**



MHS DQ Management Control Program

Service Results

The following General Comments, "Barber Pole", and Charts outline the summarized results of the Data Quality Commander's Statements submitted by each Service for Jul 04 (Data Month May FY04).

- **Metric Standards (colors) are as follows:**
  - **Green - 95-100**
  - **Yellow - 80-94**
  - **Red - 0-79**

2004 UBO Pilot Training

"Strengthening the Back End Processes"

MHS DQ Management Control Program :

How are we doing this year? See attached Excel Worksheets-Below is an example

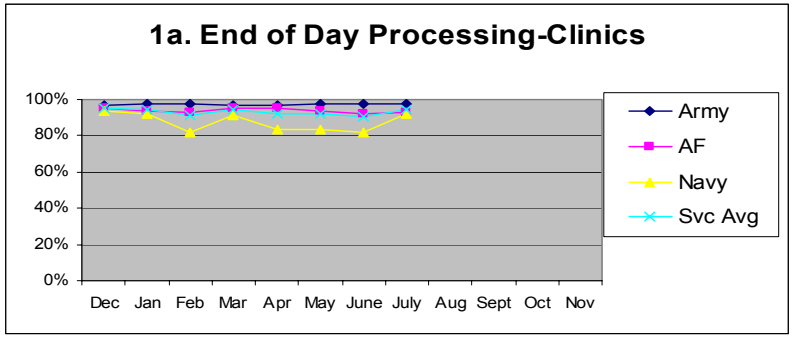
March (January (FY04) Data Sources) 2004 DQMC Commander's Statement TMA Summary Sheet (19 April, 2004)

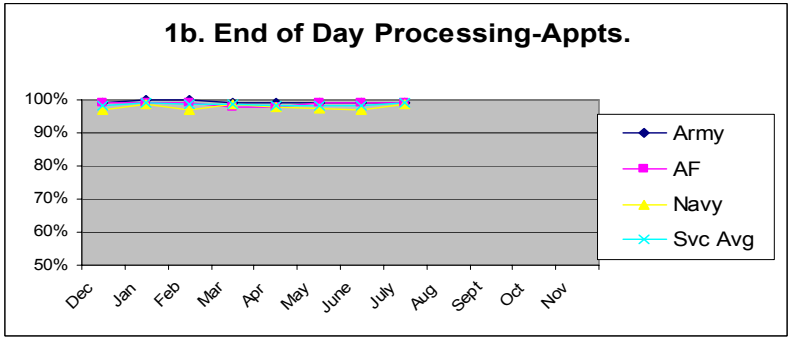
NOTE: Where answer is yes or no, Y=1, N=0; where element asks for rate, enter actual rate.
Color Code: Green (95-100), Yellow (80-94), Red (79 and below)

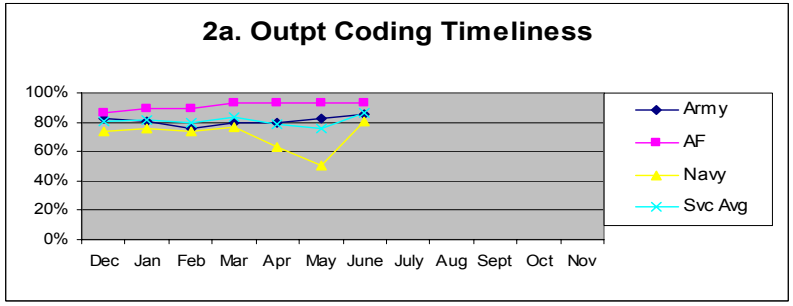
	Percent Compliant				Percent Compliant				Percent Compliant				Percent Compliant			
	Dec-03	Dec-03	Dec-03	Dec-03	Jan-04	Jan-04	Jan-04	Jan-04	Feb-04	Feb-04	Feb-04	Feb-04	Mar-04	Mar-04	Mar-04	Mar-04
	Army	Air Force	Navy	Svc Avg	Army	Air Force	Navy	Svc Avg	Army	Air Force	Navy	Svc Avg	Army	Air Force	Navy	Svc Avg
QUESTION KEY:																
1. Adherence to requirements for *daily* end-of-day processing procedure by all clinics																
a. Percentage of clinics in compliance	97%	95%	94%	95%	98%	94%	93%	95%	98%	93%	82%	91%	97%	95%	92%	95%
b. Percentage of appointments closed	99%	99%	97%	98%	100%	99%	99%	99%	100%	99%	97%	99%	99%	98%	99%	99%
2. IAW legal and medical coding practices have all the following occurred:																
a. % of Outpt. Encounters (non-APV) coded within 3 business days of encounter	83%	86%	74%	81%	81%	89%	76%	82%	76%	89%	74%	80%	80%	93%	76%	83%
b. % of APVs coded within 15 days of encounter	79%	75%	83%	79%	76%	77%	84%	79%	77%	87%	81%	82%	77%	80%	78%	78%
c. % of Inpt records coded within 30 days after discharge	81%	90%	91%	87%	83%	74%	94%	84%	86%	88%	91%	88%	92%	95%	95%	94%
3. IAW with TMA policy, "Implementation of EAS/MEPRS Data Validation and Rec"																
a. Monthly EAS/MEPRS financial reconciliation process was completed and validated	94%	71%	65%	77%	94%	71%	73%	79%	97%	79%	80%	85%	97%	90%	77%	88%
b. Monthly Inpt. and Outpt. EAS/MEPRS reconciliation processes cpleted/vldated	97%	82%	81%	87%	94%	80%	86%	87%	97%	78%	97%	91%	97%	97%	97%	97%
c. Were the data load status, outlier/variance, WWR-EAS IV, & Alloc. Tabs in MEWACS reviewed and anomaly explanations given	100%	81%	84%	88%	97%	88%	87%	91%	100%	84%	93%	92%	100%	95%	93%	96%
4. Compliance with TMA or Service guidance for timely submission of data																
a. MEPRS/EAS	86%	48%	74%	69%	92%	54%	80%	75%	97%	69%	90%	85%	89%	91%	90%	90%
b. SIDR/CHCS	100%	94%	96%	97%	96%	96%	96%	96%	100%	100%	100%	100%	86%	95%	100%	94%
c. WWR/CHCS	100%	96%	97%	98%	100%	97%	97%	98%	100%	100%	100%	100%	100%	100%	100%	100%
d. SADR/ADM	94%	90%	100%	95%	97%	91%	100%	96%	94%	100%	100%	98%	89%	94%	100%	94%
5. Outcome of monthly inpatient coding audit (DRG codes)	98%	93%	97%	96%	98%	90%	98%	95%	95%	92%	96%	94%	96%	95%	96%	96%
6. Outcome of monthly coding audits (# validated/# reviewed)																
a. % of records available for audit (O.H.or C.O.)	98%	86%	92%	92%	99%	91%	92%	94%	99%	90%	90%	93%	99%	88%	93%	93%
b. % of E&M codes deemed correct	82%	71%	78%	77%	86%	71%	82%	80%	82%	70%	79%	77%	84%	70%	78%	77%
c. % of ICD9 codes deemed correct	83%	67%	80%	77%	81%	73%	77%	77%	84%	69%	79%	77%	80%	67%	79%	75%
d. % of CPT codes deemed correct	91%	71%	82%	81%	91%	73%	85%	83%	89%	69%	83%	80%	92%	69%	83%	81%
e. % of completed & current DD Form 2569s maintained in the record (Non-AD)	46%	53%	32%	44%	44%	60%	32%	45%	48%	60%	45%	51%	52%	58%	48%	53%
7. Comparison of reported workload data																
a. # SADR/# WWR visits	98%	98%	95%	97%	100%	100%	93%	98%	99%	96%	95%	97%	100%	96%	98%	98%
b. # SIDR/# WWR dispositions	100%	92%	99%	97%	100%	95%	99%	98%	100%	95%	100%	98%	100%	94%	99%	98%
c. # EAS/# WWR visits	95%	91%	100%	95%	96%	90%	100%	95%	93%	93%	100%	95%	95%	100%	100%	98%
d. # EAS/# WWR dispositions	96%	85%	97%	93%	96%	88%	100%	95%	91%	87%	100%	93%	96%	99%	100%	98%
8. I am aware of data quality issues identified by the DQMC Review list and when needed, have taken action to improve the data from my facility.	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

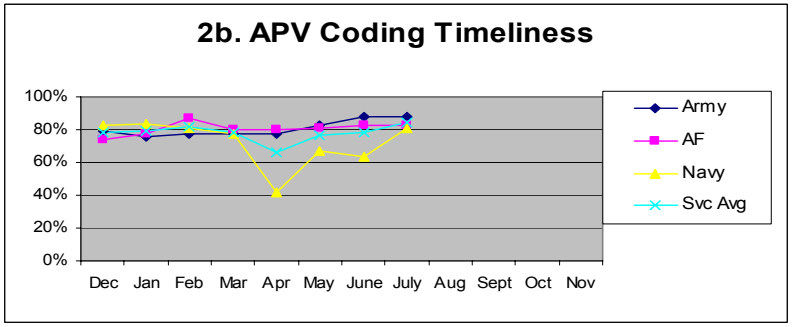
MHS DQ Management Control Program :

FY04 Trends on Commander's Statement



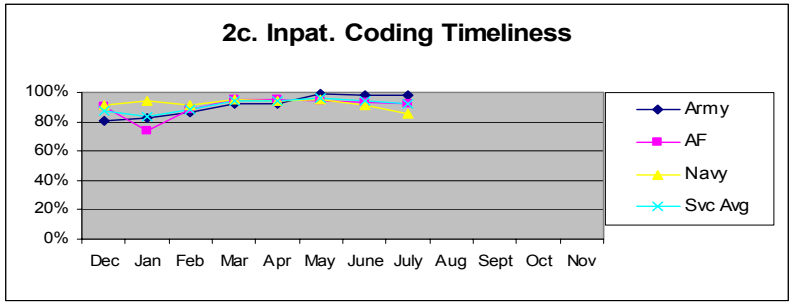


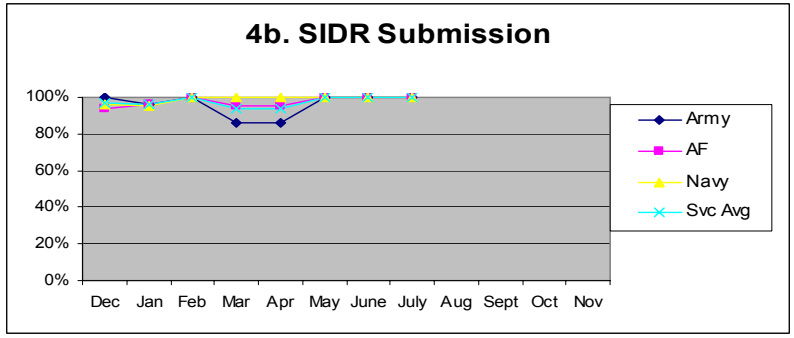


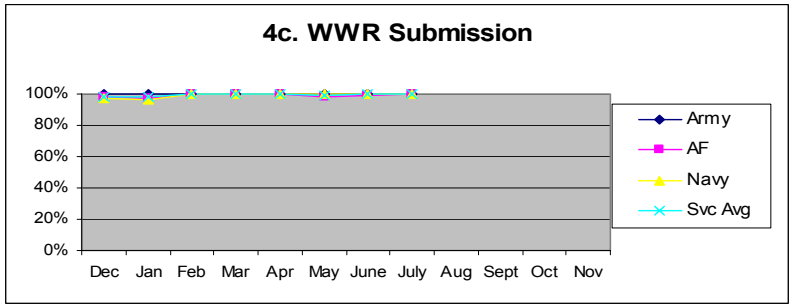


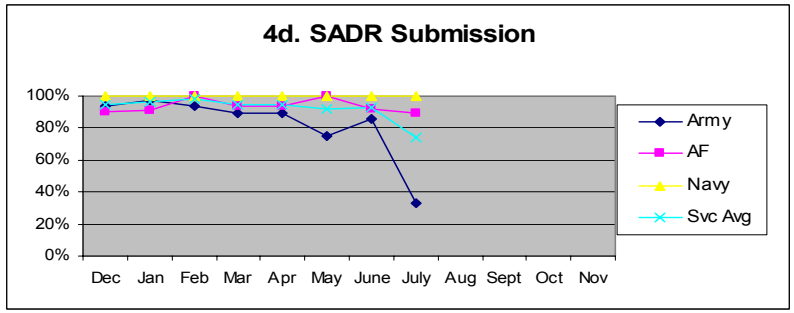
MHS DQ Management Control Program :

FY04 Trends on Commander's Statement



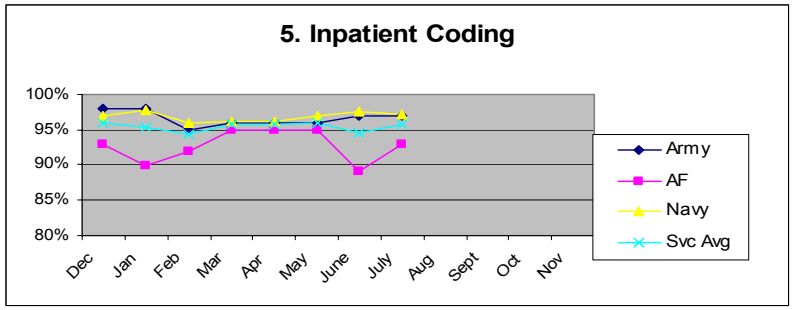


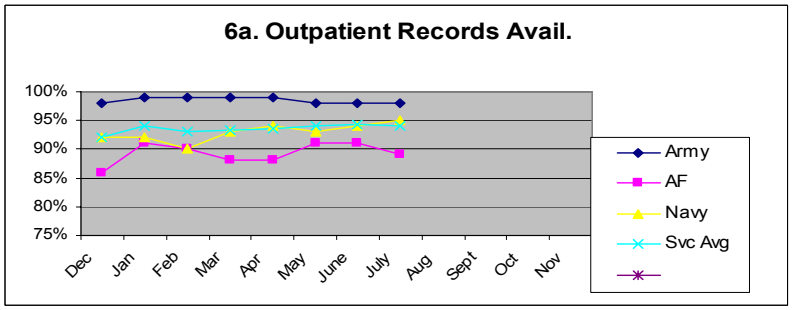


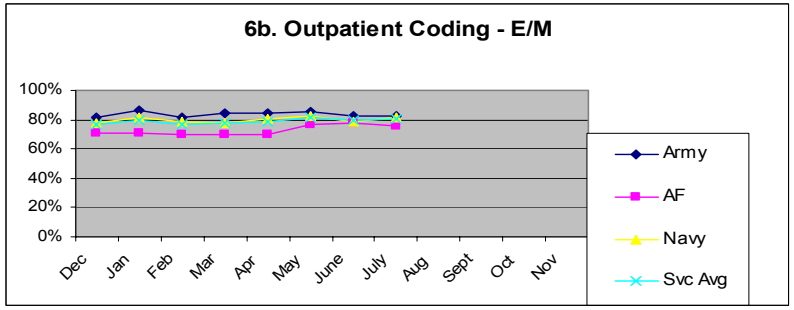


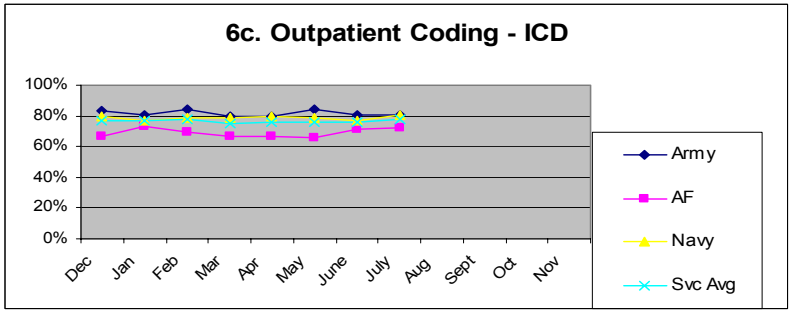
MHS DQ Management Control Program

FY04 Trends on Commander's Statement









MHS DQ Management Control Program

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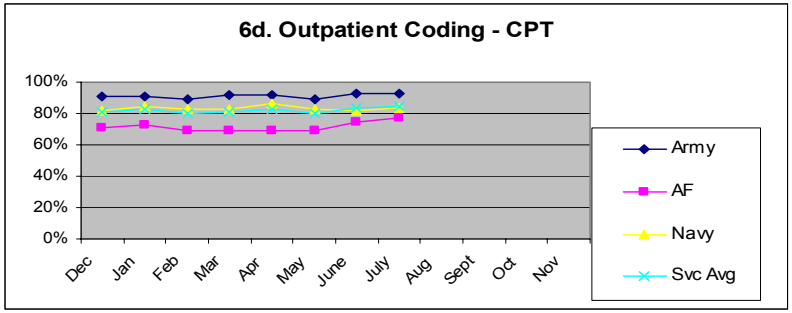

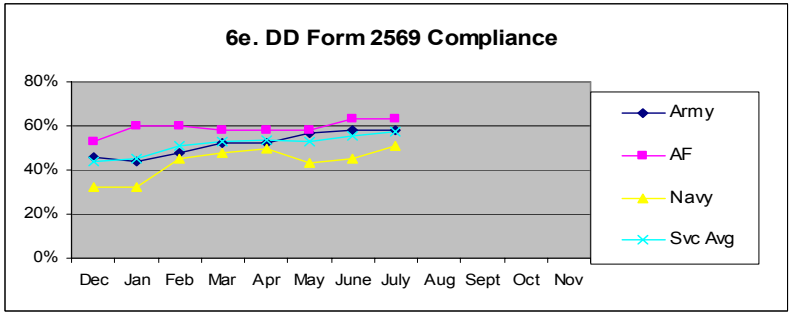

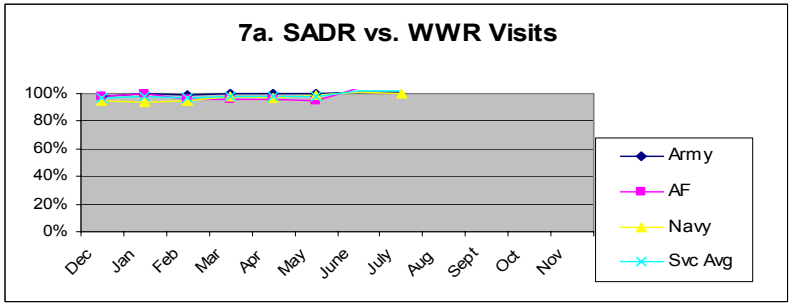

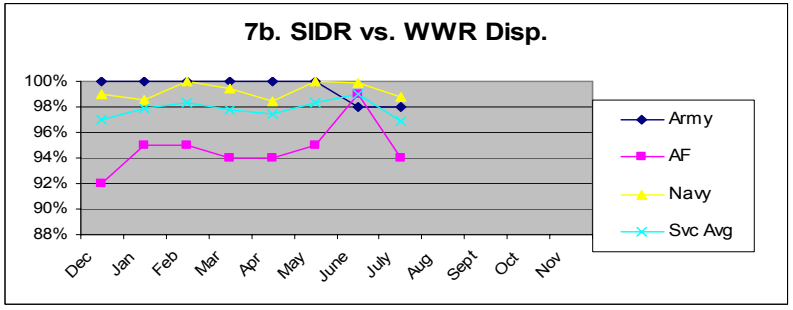

MHS DQ Management Control Program

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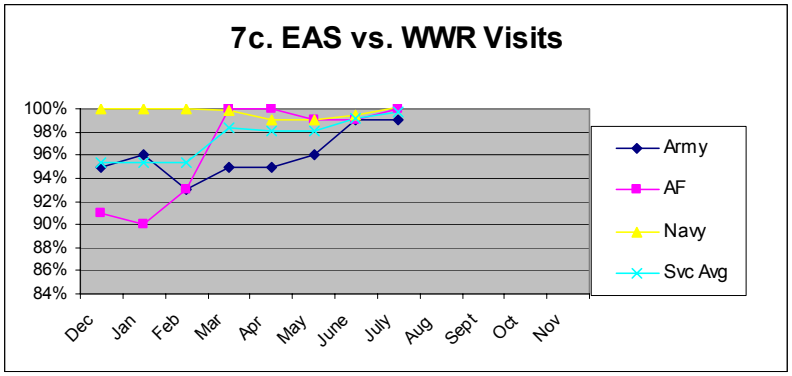
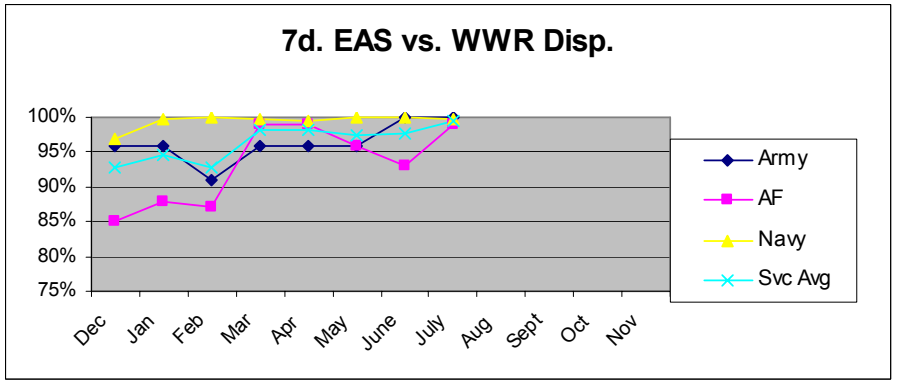
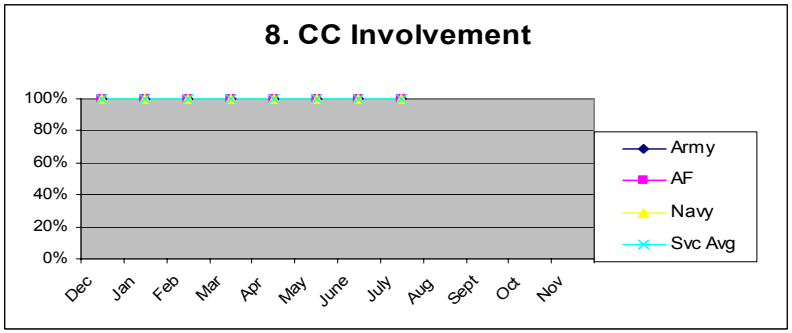






MHS DQ Management Control Program

DoD-IG MTF Specific Comments

- Responses to the Commander's Statements and Control Review Lists are unreliable. Need audit/-validation of responses in the Commander's Statement/Review List.
- Lack of audit trail - no supporting documentation.
- Lack of accountability.
- Lack of training.
- Inadequate dedication of resources to data quality.

MHS DQ Management Control Program

Concerns

- Prevents DHP and OSD from receiving a "Clean Audit Opinion."
- Puts future DHP funding in jeopardy.
- Puts Prospective Payment in jeopardy.
- Third Party Collections (TPC) placed in jeopardy.
- Jeopardizes Managed Care Support Contract BPAs/REAs.
- Jeopardizes MTF Accrual Financing Reimbursement

MHS DQ Management Control Program

Management Plan (Jul 01)

- DoD-IG (Service Directs) - Memo signed 17 Oct 01
- Clarify DQMC Review List Questions. – Service initiative began work on 13 Jul 01 - Completed
- Training
  - Web-Based Solution - Enhance current DQ/DQMC Web Site i.e. FAQs etc. - Completed
  - Current Quarterly Data Quality Training Class - Completed
- Compliance Monitoring (Service IG, IC, Audit Agency, ARS Bridge Confirmation) - Memo signed 17 Oct 01
- MTF Visibility and Feedback - Memo signed 17 Oct 01

MHS DQ Management Control Program

Management Plan (Con't)

- Leverage Service Data Analysis Capability (Army PASBA etc.) Working/Discussed at DQMC Meeting
- "Low Hanging" Enhancements (e.g. CHCS Workload Accounting Enhancements, Automated Reporting) - Funded
- Investigate Coding Improvement initiatives - Working
- Continue EAS-IV Implementation Oversight - Working
- "Spread the Word" - Brief DQMC Program at Various TMA and Service-level events.
- DQMC Program incorporated into a Department of Defense Instruction (DoDI) – 26 Nov 02

MHS DQ Management Control Program

External Audit Results (CY02)

External Audit Results (CY03)

MHS DQ Management Control Program

Findings CY02

Iowa Foundation - 50 sites, 11,254 cases

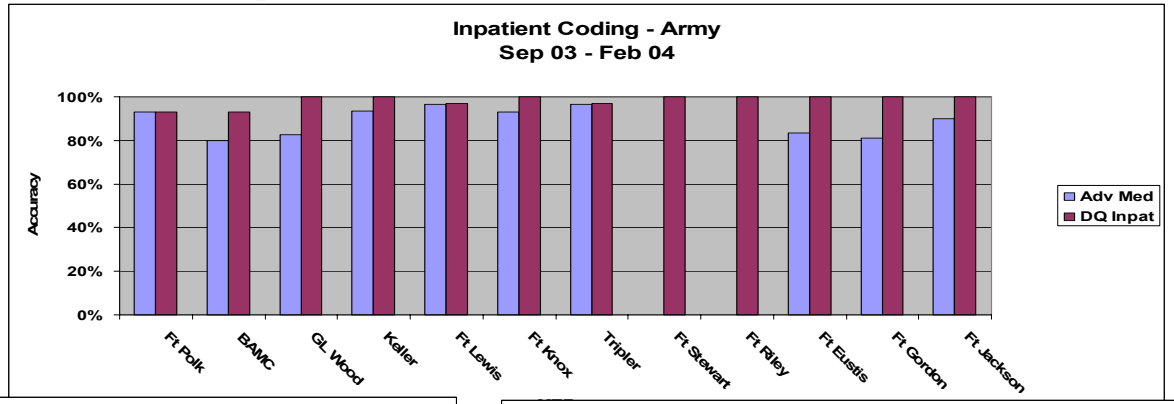
- Unavailability of records (47%).
- Specific encounter not found in 9% of the records.
- Coded incorrectly, 27%; 70% over coded, 30% under coded.
- Coded correctly, 17%.

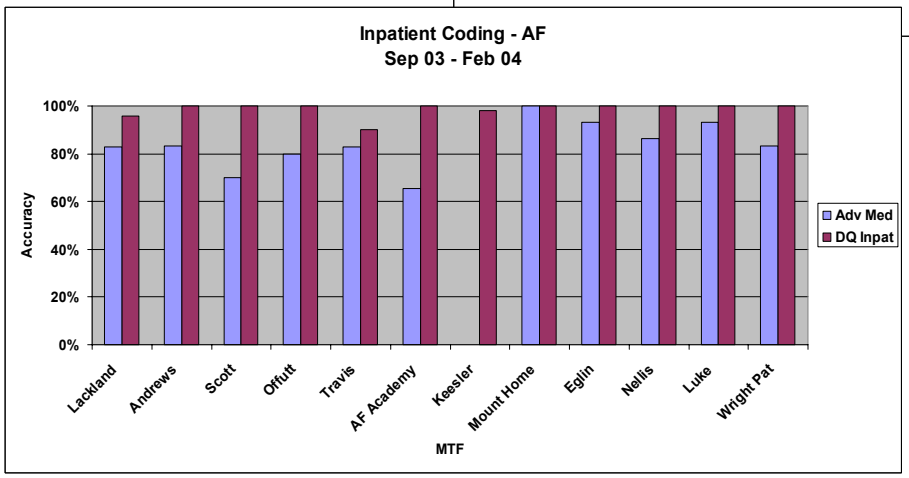
Advancemed – Similar results

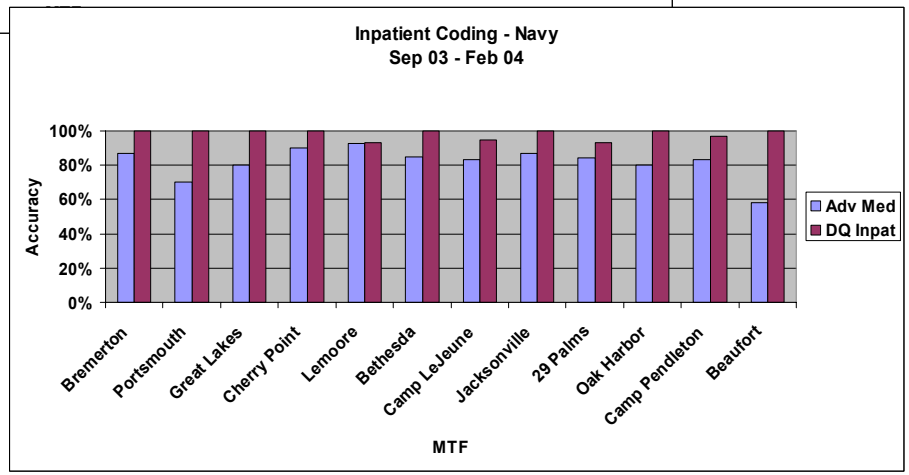
Availability of records (9%).

MHS DQ Management Control Program

MTF Reported vs Advance Med Audit







MHS DQ Management Control Program

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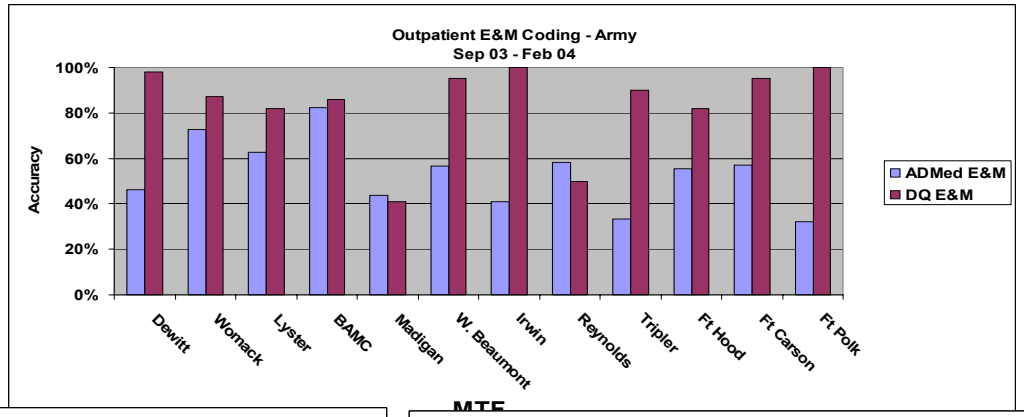

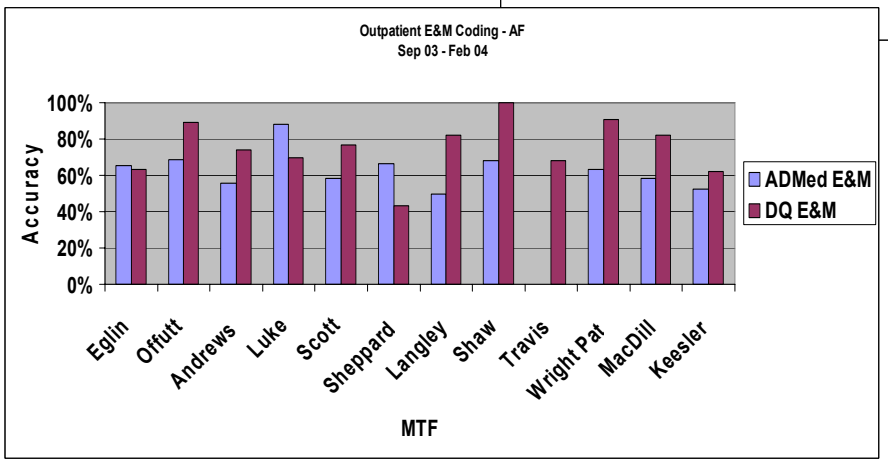

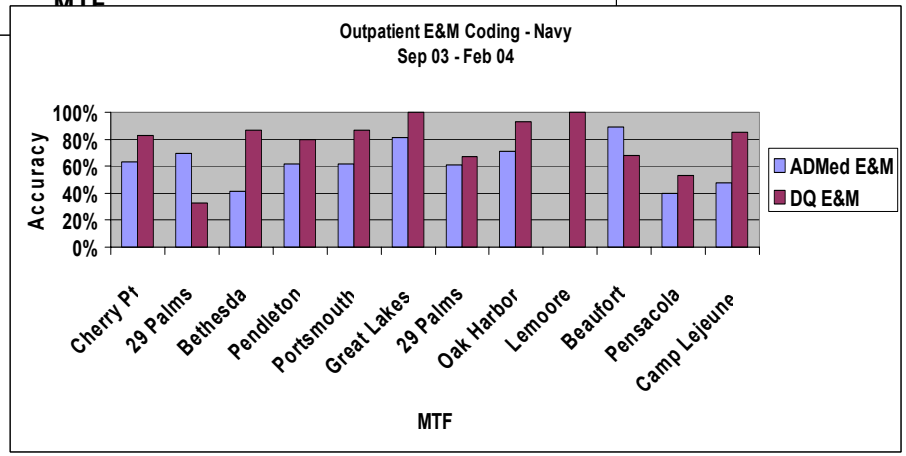

MHS DQ Management Control Program

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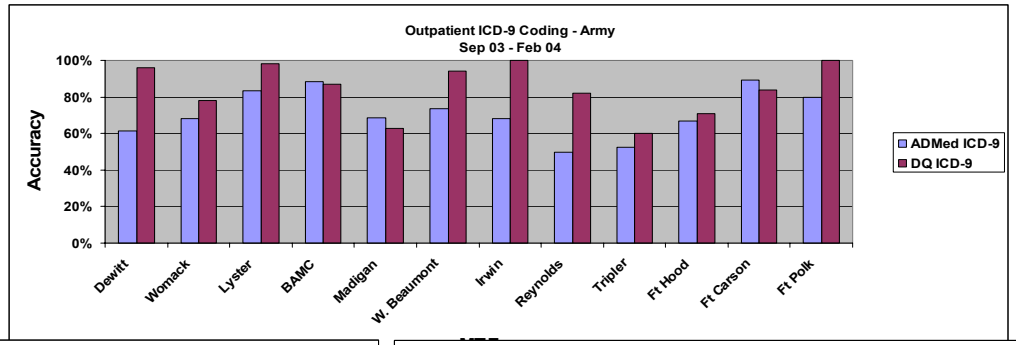

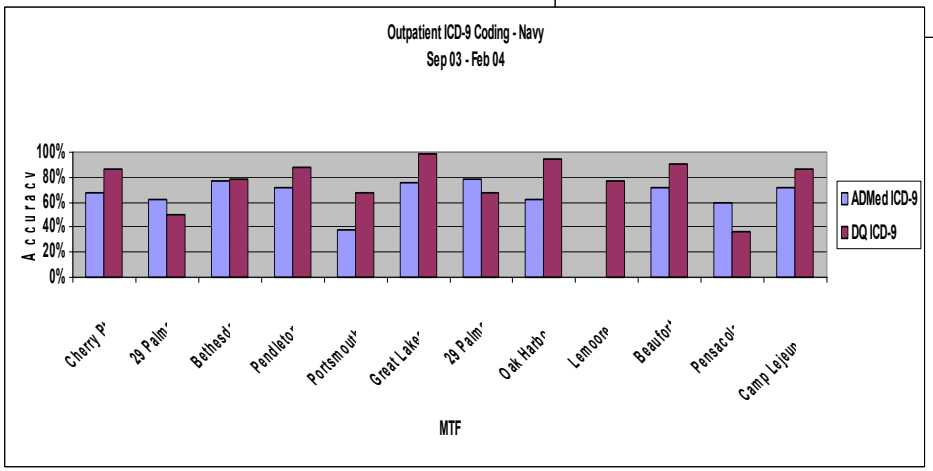

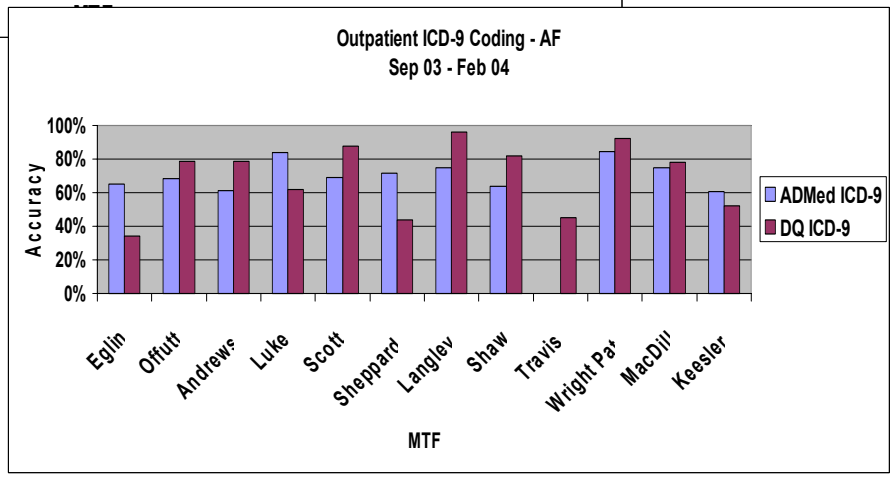

MHS DQ Management Control Program

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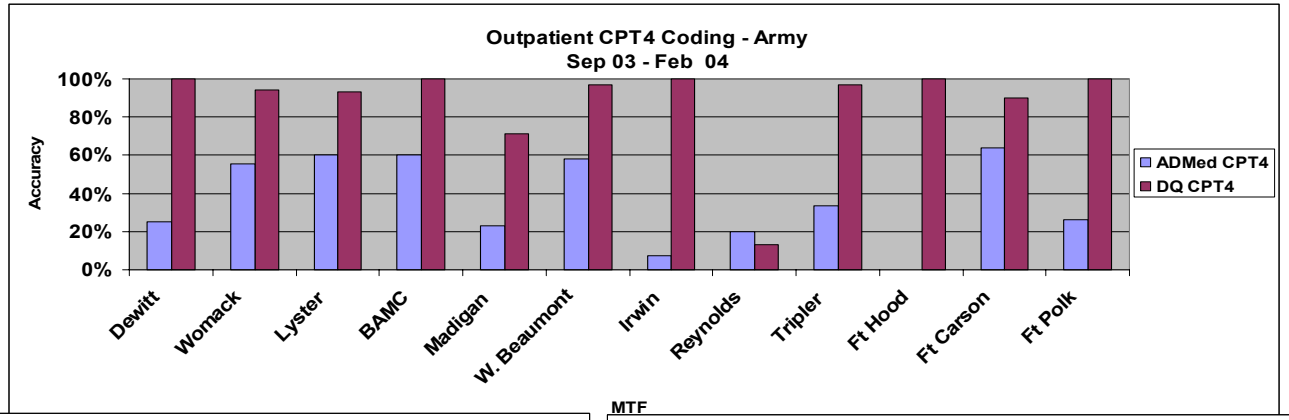

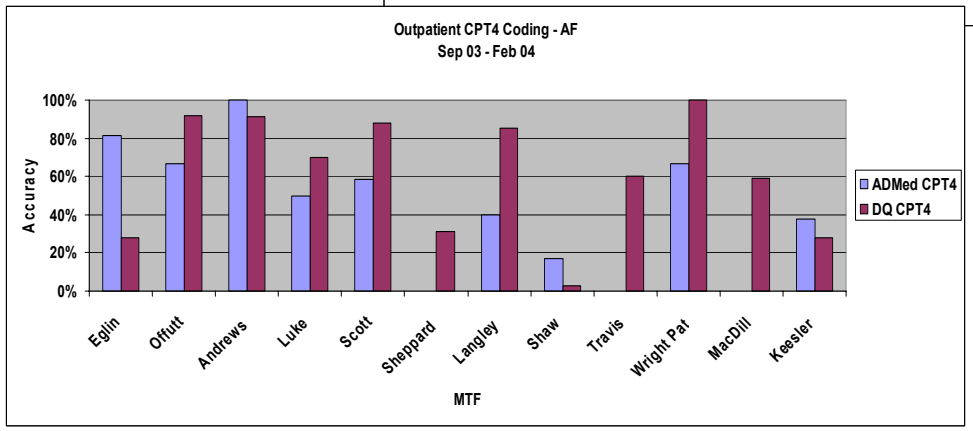

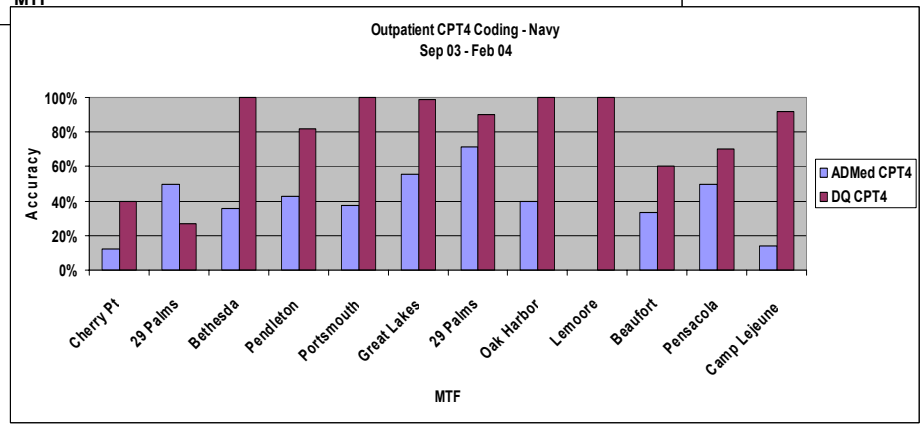

MHS DQ Management Control Program

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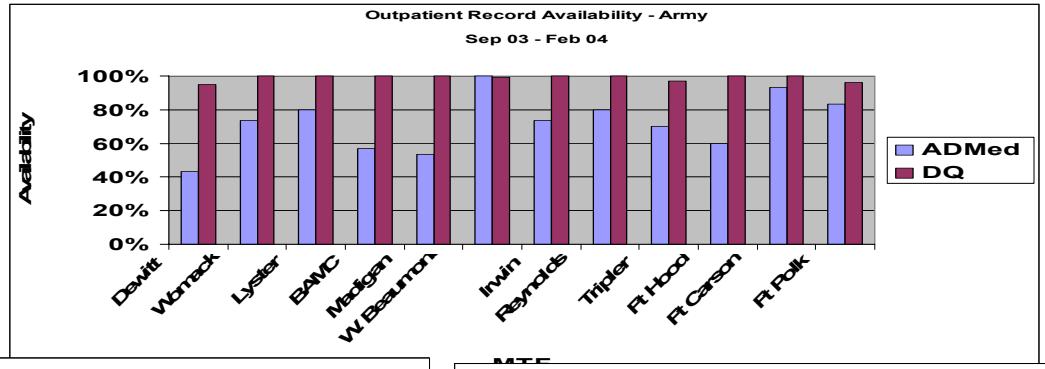
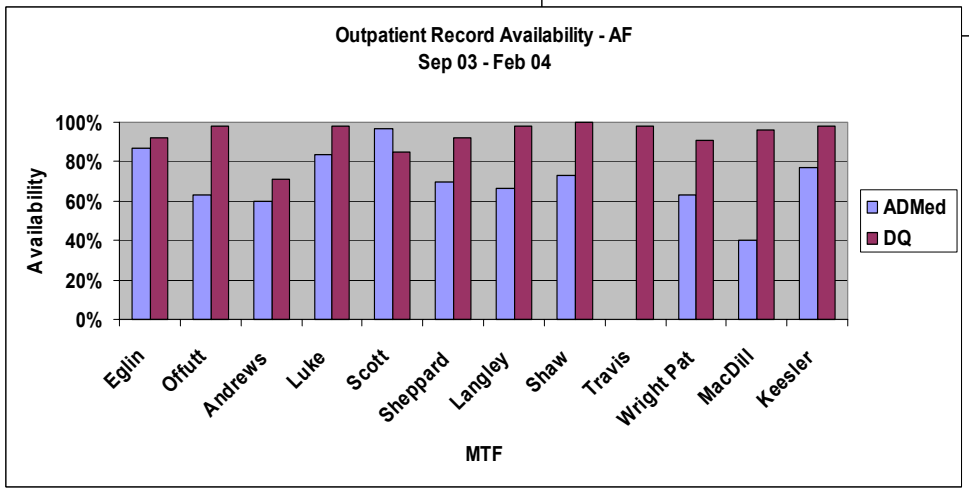
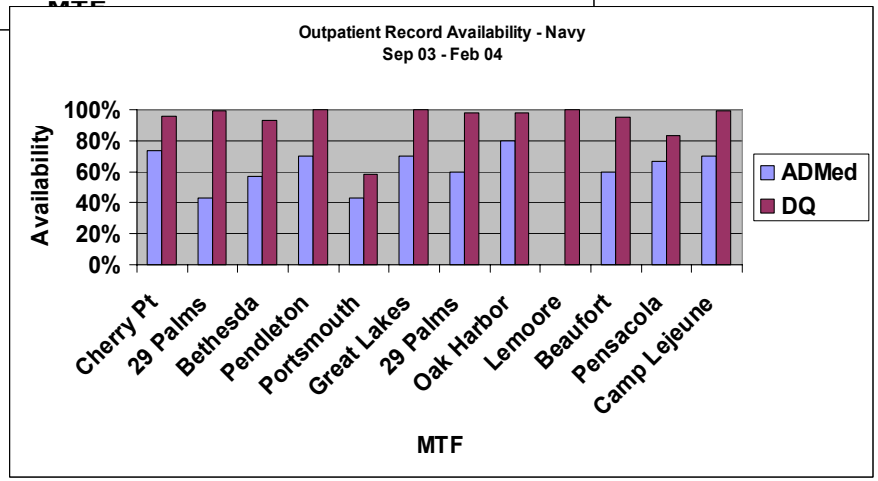






MHS DQ Management Control Program

Modalities/FY03/04 Plan

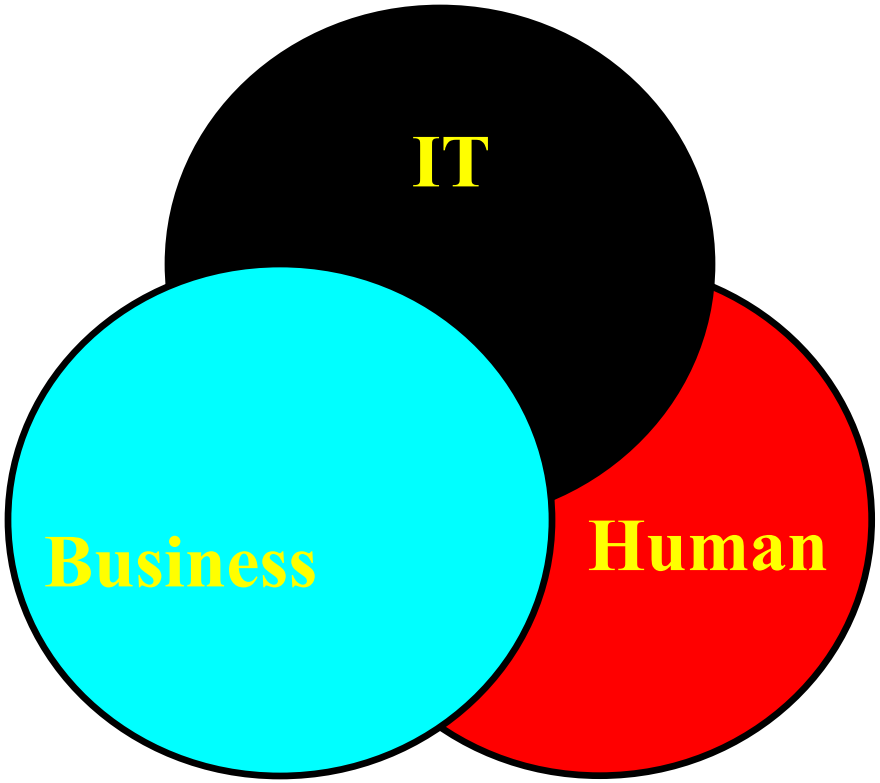
- **Policy Memoranda, DoD Directive and Instructions**
  - **Two memos to Assistant Secretaries for M&RA**
    - **One overarching DoDD—Signed 13 Apr 04**
    - **Two DoDIs—Signed 10 Jun 04**
- **Training (160 at DQ Course FY03 – YTD)**
  - **Course modified to "Teach Me How…"**
  - **350+ briefed at 2003 MEPRS Conf**
  - **Taught Navy PAD, TEFMEP courses, UBO**
- **Performance Metrics**
  - **DoDI 6040.40 of 26 Nov 02 (Data Quality Management Control)**
- **Internal Compliance, External Evaluation**
  - **Memo to Assistant Secretaries for M&RA (IG/Audit Service)**
  - **Audit Contract**

MHS DQ Management Control Program

Benefits

- **Availability of records provide the communications link between providers; continuity of care.**
- **Record/coding provides evidence of treatment, supports budget, reimbursement, billing.**
- **Record/coding supports training and education.**
- **Record/coding facilitates quality assurance processes.**
- **Record provides the legal defense for patients, providers, MHS.**

An Ongoing Challenge



MHS DQ Management Control Program

How Can You Help

- **Brief medical staff on command data.**
  - **Executive Steering Committee**
  - **Department and Division Heads**
- **Develop Dashboards.**
- **Provide feedback to staff.**
- **Participate/knowledgeable data quality at your MTF.**
  - **Reporting**
  - **Analysis**
- **Network and share information.**

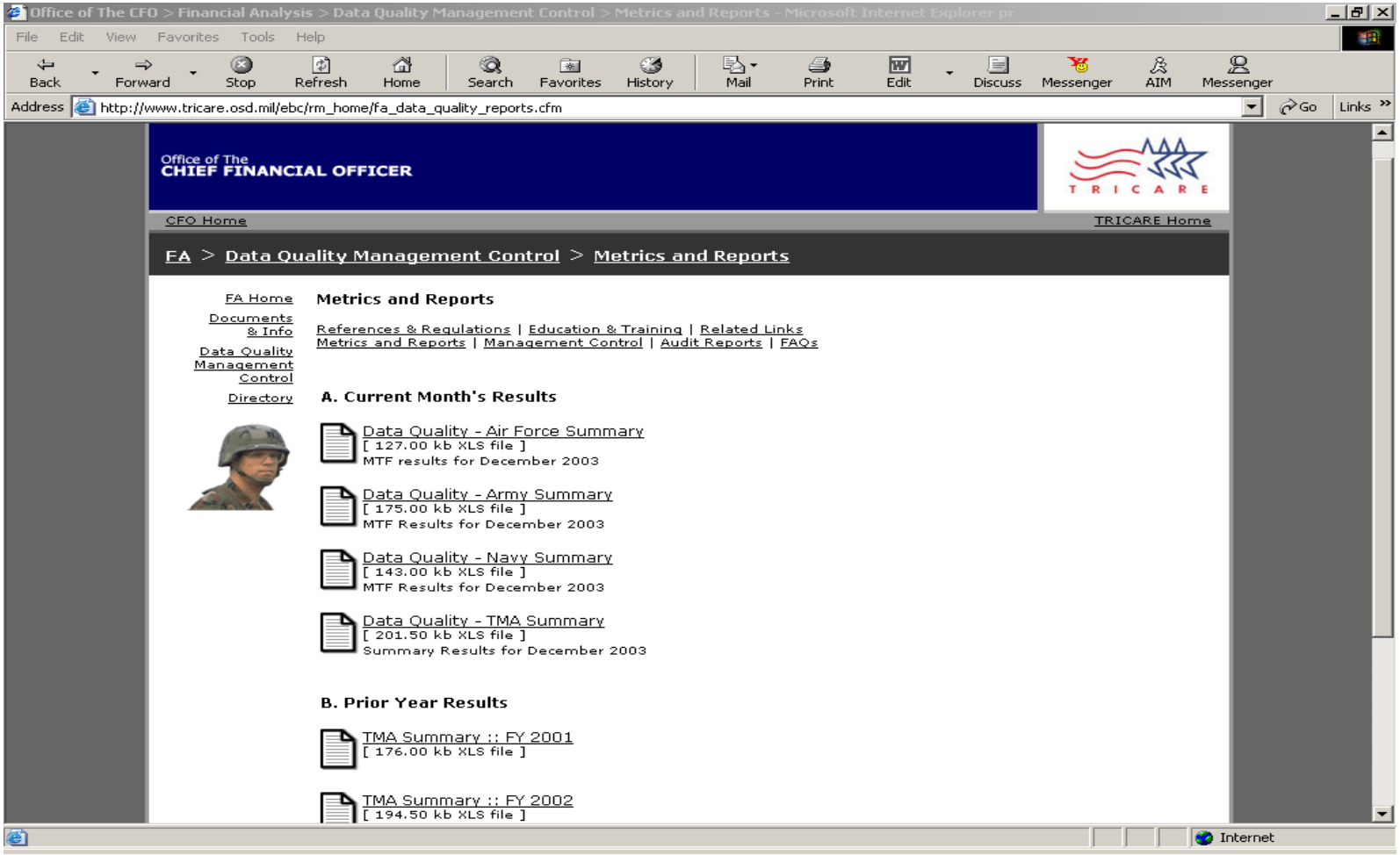
MHS DQ Management Control Program

Service Data Quality Managers

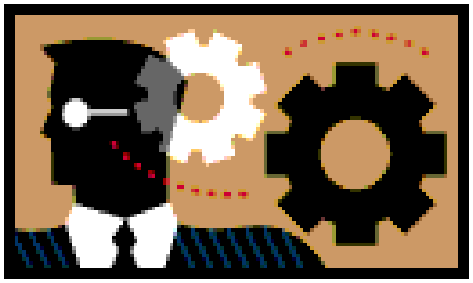
Army	**Ms. Garnet Robinson** **Telephone: (210) 221-1389 DSN 421** **garnet.robinson@amedd.army.mil**
Navy	**Ms. Jane Cunningham** **Telephone: (202) 762-0551 DSN 762** **jmcunningham@us.med.navy.mil**
USAF	**MSgt. Joann Milster** **Telephone: (703) 681-6504 DSN 761** **joann.milster@pentagon.af.mil**
://tricare.osd.mil/ebc/rm_home/fa_home.cfm	

MHS DQ Management Control Program

TMA DQ Website



Questions?



"Your Honor"

The Potential for Litigation Against an MTF

How simple mistakes can get out of control

- Provider registration in the pharmacy
  - Entering a fake civilian provider DEA or License ID
  - Entering the wrong location
  - Entering the wrong set of specialties
  - Knowingly selecting a convenient name, or the first item on the pick list
  - Selecting an improper provider clinic
- If a lawsuit is filed, and a pattern is found, the MTF loses.
- Ignorance of data quality issues will not justify the downstream problems that can occur.

- FRAUD
  - Deceit, trickery; a: Intentional perversion of truth in order to induce another to part with something of value or to surrender a legal right. B: An act of deceiving or misrepresenting.
    - (Merriam-Webster's Collegiate Dictionary, Tenth Edition)
- Abuse
  - Practices that directly or indirectly result in result in unnecessary costs.
    - (Hospital Chargemaster Guide 2004)

Examples of fraud

- Billing for services or supplies that were not provided
  - (appointment not kept, prescription not picked up)
- Split billing
  - (i.e. 90 day supply 3 times for 30, unbundling labs)
- Misrepresenting the diagnosis
  - (upcoding)
- Submitting a claim for non-chargeable services, supplies or equipment
  - (DME/DMS)
- Claiming bad debt without first genuinely attempting to collect payment
  - (Due Process)

System Reports

There are three standards to "judge" whether a service is abusive:

- Is the Service medically necessary?
  - (Documentation is the key)
- Does the service conform to professionally recognized standards?
  - (Medical necessity)
- Is the service provided at a fair price?
  - (CHAMPUS Allowable Charge (CMAC) rates are established under 32 CFR 199.14)

Covered vs. Noncovered vs. Nonbillable Services

- Know the rules
  - 32 CFR 220
  - 10 USC1095
  - TMA/UBO Policy and guidance
  - Service Specific Guidance
- If charges are generated for nonbillable services, the billing staff should delete them from the claim. Example: DME/DMS

System Reports

- The biller is responsible for knowing and following national coverage and billing guidelines as delineated in federal statutes, regulations, coverage issues, and billing manuals.
- Billers are also expected to remain aware of new and changing policies and stay current with all coverage regulations

Questions?

File and Table Settings

What is the difference in a File and Table

- A table is fixed (generally supplied by the government example: NDC Numbers, Provider Class, etc)

- A File is generated by a member of the MTF or someone that has system access and can be changed when appropriate

- Your System Administrator will have access to all files and tables
  - Each unit/clinic should ensure that files are accurate, deleted when appropriate and updated when errors are found

- CODE: 01 DESCRIPTION: MEDICAL DOCTOR/DOCTOR OSTEOPATHY
- CODE: 02 DESCRIPTION: MENTAL HEALTH PROVIDER
- CODE: 03 DESCRIPTION: ADDITIONAL MENTAL HEALTH PROVIDER
- CODE: 04 DESCRIPTION: ADDITIONAL MEDICAL PROVIDER
  - Optometrist
  - Physical Therapist
  - Physician Assistant
  - Nurse Practitioner
  - Etc

Provider Specialty
Name: BRIDDELL,CONNIE
Provider Flag: PROVIDER
Provider ID: BRIDCON
Provider Class: PHYSICIAN STAFF 1P
SSN: 080-99-1212
Select PROVIDER SPECIALTY:
+ INTERNIST
+ CARDIOLOGIST
Primary Provider Taxonomy: 207R00000X
CMAC Provider Class: 01 - MEDICAL DOCTOR/DOCTOR OSTEOPATHY
Select PROVIDER TAXONOMY:
207LC0200X
+ 207P00000X

Location: INT MED CL BE
HCP SIDR-ID: 011AAO
Branch of Service: ARMY
Rank: LIEUTENANT COLONEL

* * * PATIENT CATEGORY BILLING TABLE * * *

Code	Description	Inpatient Ind	Inpatient Agy	Outpatient Ind	Outpatient Agy	Pay Mode
K71	FMS NATO CIVILIAN - ITO	NC	FRR	NC	FOR	DD7/DD7A
K75	NON-NATO FAM MBR IMET/FM	NC	FLEX	NC	FOR	DD7/DD7A
N11	USN ACTIVE DUTY	SR	NC	NC	NC	DD139
N12	USN AD RES	SR	NC	NC	NC	DD139
N12	USN AD RES-30 DAYS OR LE	FRR	NC	FOR	NC	
K61	DOD/VA SHARING AGREEMENT	NC	FLEX	NC	FLXO	DD7/DD7A
N14	USN ACADEMY CADET	NC	SR	NC	NC	DD7/DD7A
N21	USN ROTC	SR	NC	NC	NC	DD139
K62	WC-DOD BENE, DOD EMPL	NC	NC	NC	NC	
B26	NOAA APPLICANT/REGISTRAN	NC	IAR	NC	IOR	DD7/DD7A
N24	USN FRM AD-TRANS ASSISTA	FMR	NC	NC	NC	
K53	FED EMPLOYEE ALCH AND DR	IAR	NC	FLXO	NC	
K71	IMET NON-NATO MILITARY/C	NC	IMET	NC	IMO	

Keep a printed copy handy

CHCS Menu: MSA -> MSR -> PCT or MSA -> IFM -> OPM -> PCT

Capture Outpatient Clinic Services and Procedures in ADM, LAB, RAD & PHR sub-systems in CHCS:

- **ADM Encounters with a Status of "COMPLETE" and Completed LAB, RAD & PHR services will be automatically assigned a "BILLING" Flag by CHCS**
- **CHCS will automatically transfer "Billable" services for processing to TPOCS, CHCS MSA or the DD7A, based on the Billing Flag assigned by CHCS**
- **Services MUST be associated with a "Billable" Provider**

- Clinic end of day completion process sets the stage for billing
- Provider file clean-up is the key to most biling problems
  - Location& Clinic ID
  - Provider Specialty
- Inactivate obsolete entries

Accounts for MSA billable services will be created three days following the date of service:

Service	**Date Based On**
Ambulatory (Outpatient) Encounter	Encounter
Laboratory Test	Specimen Collected
Radiology Exam (Technical)	Exam Performed
Radiology Exam (Tech and Professional)	Report Approved
Radiology Exam (Professional)	Report Approved
Pharmacy Prescriptions Issued	Label Printed

Key Files and Data Elements for OIB

- Patient Category Codes
- CPT Codes
- Current NDC Codes
- Correct Provider Specialty
- Entry of the requesting location for orders (linking diagnosis to request)